

ATLANTIC CANADIAN DAILY NEWSPAPER COVERAGE
OF WAIT TIMES FOR MEDICAL SERVICES

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May 8, 2007



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ABSTRACT

The purpose of this news media representation study was to explore and describe a sample of Atlantic Canada daily newspaper coverage of wait times for medical services and to make informed assertions about how this coverage can influence the public's knowledge of health services and Canadian health policy. The sample for this mixed-methods study included news articles and opinion pieces published between January 1, 2003 and December 31, 2005 from *The Chronicle-Herald* (and its Sunday edition, *The Sunday Herald*), *The Guardian*, *The New Brunswick Telegraph Journal*, and *The Telegram*. In the sample, anecdotal evidence was reported in about one of every 10 stories (40/407, 10%), while research evidence was reported the least of all kinds of reported evidence (21/407, 5.2%). Most of the stories had a negative tone (187/407, 46%), followed by a neutral tone (154/407, 38%) and a positive tone (66/407, 16.2%). Federal, provincial, territorial government sources were quoted about wait times most frequently (358/847, 42.3%) followed by physicians and physician groups (156/847, 18.4%). Government sources were also most frequently photographed (68/115, 59.1%), followed by patients (16/115, 13.9%) and non-physician health care providers (14/115, 12.2%). Four major themes arose from the qualitative content analysis including: (1) wait times indicate inadequate resources within the health care system; (2) the health care system is in a state of crisis due to long waits; (3) there is an ongoing debate over the impact of public versus private health care on wait times; and (4) greater managed care techniques will improve wait times, but confusion over which techniques are best remains. This study supports the hypothesis that the news media tend to report negative information and construct crisis when it comes to news coverage of waiting times for health services. This reporting can inspire false beliefs about the Canadian health care system, which may lead to misguided health policy and practice decisions around wait times.

CHAPTER ONE: INTRODUCTION

Timely access to care is a top health care priority for Canadians and a pressing policy challenge in Canada's publicly funded health care system (Postl, 2006; Romanow, 2002; Kirby, 2002). While the public wants and needs information about waiting times for medical services, there are concerns news media coverage of health care access leaves something to be desired.

For example, in the report, *Waiting lists and Wait times for Health Care in Canada: More Management!! More Money??*, the researchers speculated that concerns about deterioration in access to care are “often portrayed by the [news] media as new ‘crises’ despite the fact that there is relatively little objective information available on waiting times or waiting lists, in Canada, or anywhere else” (McDonald, Shortt, Sanmartin, Barer, Lewis, & Sheps, 1998, p. ii). McDonald et al. (1998) further speculated the news media have a tendency to frame these concerns around patients waiting unacceptably long periods of time on health care waiting lists. In a report published the same year, researchers argued that in the Canadian context waiting lists are characterized as “leading indicators of health-threatening access impediments to publicly funded health” (Sanmartin, Barer, & Sheps, 1998, p. 203). Nearly 10 years later, the Canadian Institute for Health Information (CIHI) report, *Waiting for Health Care in Canada: What We Know and What We Don't Know*, still names “access to care” — particularly waiting times — the “focus of intense [news] media coverage” (CIHI, 2006a, p. vii).

News media coverage is highly scrutinized and criticized by researchers and others. However, there is little research to back speculations. In fact, this study is the first of its kind (that I have been able to find) to explore news media portrayal of waiting times for medical services. This study supports the hypothesis that the news media have a tendency to report

negative information and construct crisis when it comes to news coverage of waiting times for health services. I begin by outlining the research problem, purpose, and objectives of my study.

Statement of Problem and Research Objectives

Long health care waits are generally thought to indicate general inadequacy in the Canadian health care system (Western Canada Waiting List Project [WCWL], 2001). According to the Canadian Health Services Research Foundation's (CHSRF) *Mythbuster* series (a series of research summaries giving the research evidence behind popular Canadian health care debates), "when the (news) media report on long waiting times, Canadians begin to doubt the quality of their healthcare systems" (CHSRF, 2001, p. 1). Some have gone so far as to say the erosion of public confidence in Canada's public health care system — from 61% of respondents in a 1991 Angus Reid Poll rating the system "excellent" or "very good" to 52% in 1995 and just 24% in 1999 (Greenspon, 1999) — was fuelled by extensive (news) media coverage of claims about increased waiting times for medical services (Sanmartin et al., 2000).

While there is a convincing argument that news media coverage of health care waiting times is misinformed or misleading, there is little research evidence to support the claim. However, there is significant literature on the complex nature of measuring, managing, and reducing waiting times for medical services. It is widely accepted, for example, that there is no simple prescription to remedy long health care waits (CHSRF, 2005; McIntosh, 2005; Sanmartin et al., 2000; McDonald et al., 1998). There is also consensus that achieving timely access to care requires coordination and cooperation from federal, provincial, and territorial (FPT) governments as well as health system managers, health professionals, and policy analysts, among others (McIntosh, 2005; Health Canada, 2004a; McDonald et al., 1998).

To add to the density of the topic, a 2006 pan-Canadian assessment of waiting times reported we are far from a vision of knowing how long patients wait for different types of care or what works best to reduce waits (CIHI, 2006a). Given the complexity and confusion surrounding health care waiting times, one can appreciate the potential difficulty journalists face in navigating through the literature and rhetoric on the subject, not to mention the potential difficulty in making this information available to the general public in a form it can understand and use.

Purpose and Objectives

The purpose of this news media representation study was to explore and describe a sample of Atlantic Canada daily newspaper coverage of waiting times for medical services. Specifically, there were three main research objectives:

1. to describe the general characteristics and themes that arise from Atlantic Canada daily newspaper coverage of waiting times for medical services over a specified time period and against a backdrop of the policy changes and research developments that occurred in that period;
2. to compare and contrast the characteristics and themes that arise across four specific daily newspapers over the time period specified; and
3. to make informed assertions about how news coverage of waiting times can influence the public's knowledge of health services and Canadian health policy regarding waiting times for medical services.

The sample for this study included news articles and opinion pieces (including editorials, columns, and letters to the editor) published between January 1, 2003 and December 31, 2005 from four Atlantic Canada daily newspapers: (1) *The Chronicle-Herald* (provincial edition) and its Sunday edition, *The Sunday Herald* in Halifax, Nova Scotia; (2) *The Guardian* in

Charlottetown, Prince Edward Island; (3) *The New Brunswick Telegraph Journal* in Saint John, New Brunswick; and (4) *The Telegram* in St. John's, Newfoundland and Labrador. This mixed-methods study entailed a qualitative and quantitative content analysis of newspaper documents as well as an extensive review and discussion of relevant Canadian waiting times and health literacy literature.

Definitions of Terms

Throughout my thesis I will reference several useful terms, including health and health care, waiting times, waiting lists, news media, journalism, and health literacy. While I define these and other terms more precisely in chapter two, I will provide preliminary definitions here.

In the World Health Organization (WHO) constitution of 1948, health is defined as “a state of complete physical, social and mental well-being” and not merely the absence of disease or infirmity (Ottawa Charter for Health Promotion, 1986, p. 1). This broad perspective on health recognizes that a range of factors (such as gender, culture, income and social status, personal health practices, and health services, among others) determine the health status of individuals or populations (WHO, 1998; Public Health Agency of Canada [PHAC], 1999). This study aimed to retrieve news articles concerned with only one determinant of health — health services, particularly waiting times for health services. Public and private health services are a part of the larger health care system or health sector, which also includes FPT departments of health, non-governmental health organizations, and professional associations (WHO, 1998). As I will explain in more depth in this chapter, health services receive more news coverage in Canadian daily newspapers than any other determinant of health (Hayes, Ross, Gasher, Gutstein, Dunn, & Hackett, in press).

While there remains much disagreement over how to define waiting times, the Health Council of Canada (HCC, 2005) has said “Enrollment (sic) on a wait list should take place at the time the intervention is formally booked (usually by a specialist). . . [with b]oth the original date of referral to the specialist and the booking date for the intervention . . . recorded” (p. 3). Furthermore, the waiting time “should be defined as the time from initial referral to completion of the procedure” (HCC, 2005, p. 3). Given the recent focus on defining waiting time benchmarks (or standards) for specific health care services, waiting time definitions have greater clarity these days than they did in the past (Ministry of Health and Long-Term Care, 2005). In fact, this trend towards more precise waiting times will continue as benchmarks for more health services are specified. Meanwhile, there is far less discussion over how to define a waiting list, which is a list of patients awaiting a service, such as surgery, or an appointment with a specialist, such as a cardiologist (Barer & Lewis, 2000).

The news media, a subset of the mass media, aim “to provide citizens with accurate and reliable information they need to function in a free society” (Committee of Concerned Journalists [CCJ], 2006a, ¶ 2). The profession of journalism involves reporting, analysing, or commenting on contemporary events, issues, and ideas judged to be of public interest and which are then edited and circulated to the public through print, broadcast (radio or television), or online news media (Adam, 1993).

Finally, health literacy is a newer concept that refers to how people (1) understand and use health information; (2) access suitable health services; (3) make knowledgeable health decisions; and (4) gain control over their health and well-being (Gillis and Quigley, 2004a; 2004b). Media health literacy is an even more recent concept, which recognizes the mass media

as health information resources. Although there is no consensus on how to define media health literacy, I provide insights in chapter two.

Background

Parliament unanimously passed the Canada Health Act in 1984, affirming Canada's commitment to a public health care system, in which the determining factor for accessing health services is medical necessity rather than ability to pay (Government of Canada, 1985). While the principle of accessibility is widely accepted and, in fact, protected in this legislation, many Canadians worry about long waiting times for health services and question the sustainability of the Canada Health Act's promise of reasonable access (WTA, 2005a).

Discussions of waiting times have been an issue for decades, as internationally recognized health reporter André Picard explains:

In the 1970s, the [news] media focused on wait times (and access) for abortion; in the 1980s, the issue was the wait for [Magnetic Resonance Imaging] and [Emergency Rooms]; in the 1990s, it was cancer care, and heart procedures. Today, it's hip replacements and cataracts. And in the near future, the issues will be wait times for home care and nursing home care. (A. Picard, personal communication, June 15, 2005)

In recent years (and as I will explain in the next section), governments and other groups have made significant strides to improve waiting times for medical services. In this section, I provide a brief history of the issue of waiting times for medical services in Canada (see Appendix A for a more complete timeline of events on waiting times). This history sheds light on the complexity of health care waits and how the issue has evolved (and has yet to evolve) since the late 1990s. In this section, I also provide an overview of the purpose of journalism, the role of the journalist, and the concept of the "good story."

A Brief History of Waiting Times

Health Canada commissioned a review calling for a national push to invest in information and access management systems in 1998 (McDonald et al., 1998). Since then, FPT agreements in 2000, 2003, and 2004 have addressed the need for access to quality health care. Tracking this history offers some insights into the FPT governments' willingness to take this issue seriously.

In the First Ministers' Meeting Communiqué on Health in September 2000, the federal government and the provincial and territorial governments (with the exception of Québec) voluntarily agreed to regularly report on health performance indicators to the public, including reporting on quality of service indicators such as waiting times for key diagnostic and treatment procedures (Advisory Committee On Governance and Accountability, 2004; Canadian Intergovernmental Conference Secretariat, 2000). Each jurisdiction produced its first report in September 2002.

After further discussions on indicator reporting at the 2003 First Ministers' Accord on Health Care Renewal (the Health Accord), the First Ministers agreed to continue regular reporting of health indicators, expanding their theme areas for reporting to include timely access, which included indicators for waiting times as well as access to health care providers and services (Health Canada, 2003). Each jurisdiction produced its second performance indicators report in November 2004.

It was also in the 2003 Health Accord that FPT governments committed to the establishment of a national Health Council (Health Canada, 2003). The HCC was established in December 2003 and has since formed a Wait Times Committee to report on waiting times (Health Canada, 2004a).

The September 2004 First Ministers' Meeting on the Future of Health Care made reducing waiting times for key procedures a priority for governments (Health Canada, 2004b). It was at this time the federal government offered significant funds to the provinces and territories to continue their work on managing and reducing waiting times for patients in those areas (Health Canada, 2004b). Some provinces and regional health authorities have since created registries and waiting list management systems as well as published waiting time information on department of health web sites (see Appendix B for a list of provincial and territorial waiting time initiatives).

In addition to jurisdictional initiatives, several projects and alliances have surfaced in recent years. One notable project is the Western Canada Waiting List Project (WCWL), “a collaborative initiative of 20 partners that [in addition to Health Canada and the four Western provinces] also includes regional health authorities, medical associations and research centres” (Health Canada, 2004a, ¶ 9). Similarly, we have seen the establishment of the Wait Time Alliance (WTA, 2005b) — a physician alliance formed in fall 2004 and comprised of several national medical specialty societies.

Most recently, the federal government proposed its “five in five” proposal, which “aim[ed] to significantly reduce waiting times over five years in five key areas [which are high priority areas for Canadians] — cancer, heart, diagnostic imaging, joint replacement and sight restoration” (Health Canada, 2004a, ¶ 10). The proposal — part of the 2004 10-Year Plan to Strengthen Health Care — entailed a commitment to develop benchmarks for medically acceptable waiting times in the five areas by December 31, 2005 so meaningful reductions could be realized by March 31, 2007 (WTA, 2005a).

Before reaching the milestone to set these benchmarks, the nation's focus was on what has popularly been referred to as "the Chaoulli decision." The Supreme Court of Canada's historic decision in the Chaoulli/Zeliotis case on June 9, 2005 underscored the importance of reducing waiting times for publicly funded health services (WTA, 2005a). Jacques Chaoulli, a physician from France now working in Québec tried to get a licence so he could offer his services as a private provider. Given provincial legislation prohibiting private health insurance, Chaoulli's request was rejected. Meanwhile, George Zeliotis, Chaoulli's patient, felt he had to wait too long for a hip operation in Québec hospitals and later challenged his wait (with Chaoulli) in a Québec court. Although Chaoulli and Zeliotis lost their trial in Québec, they were successful in their Supreme Court of Canada appeal.

The Supreme Court's decision overturned the lower court ruling preventing Québeckers from buying private health care insurance for publicly insured services (ultimately because of the provincial government's perceived failure in handling surgical waiting times) (WTA, 2005a). Many saw this decision as a bleak reminder that long waits in the public health care system can endanger people's lives (WTA, 2005a). According to the WTA (2005a), "the decision [also pointed] to an urgent need for governments to work collaboratively with health care providers and patients to lay out a roadmap that will provide Canadians with more timely access to high-quality care" (p. 1).

At the end of 2005, First Ministers announced the release of Canadian benchmarks for common procedures, making it possible to measure progress in reducing waiting times (Ministry of Health and Long-Term Care, 2005). Based on the best available research and clinical evidence, provinces and territories proposed to provide radiation therapy to treat cancer within four weeks of patients being ready to treat; hip fracture fixation within 48 hours; hip

replacements within 26 weeks; knee replacements within 26 weeks; surgery to remove cataracts within 16 weeks for patients who are at high risk of complications (for example, blindness) from cataracts; breast cancer screening for women aged 50 to 69 every two years; and cervical cancer screening for women aged 18 to 69 every three years after two normal tests (Ministry of Health and Long-Term Care, 2005). For cardiac bypass surgery, three benchmarks were established: the most urgent patients (classified as Level I) are to be seen within two weeks; others are to be seen within six or 26 weeks (Level II and Level III patients, respectively) (Ministry of Health and Long-Term Care, 2005).

In the future, it is expected that more waiting time benchmarks will be developed as new research evidence is produced (CIHI, 2006a). To make this happen, provinces and territories will continue to collaborate with the federal government, the Canadian Institutes of Health Research (CIHR), and some of Canada's top clinicians (Barer, 2006). Meanwhile, provincial and territorial governments will continue to pursue their own strategies to improve access and, by the end of 2007, establish multi-year targets to achieve national waiting time benchmarks (CIHI, 2006a). Also during this time, jurisdictions will continue to improve how they measure, monitor, and manage waiting times (CIHI, 2006a).

A review of the history tells us the last decade in particular has seen much advancement in the way we measure, monitor, and manage waiting times. However, much work remains if we are to make these tasks a systematic and routine part of everyday health care. Regardless, members of the public want and need this information so they may better manage their health and successfully navigate an increasingly sophisticated health care system. For those who report on health care waits, the task appears anything but simple.

The Role of a Journalist

The main purpose of journalism is to provide the public with an accurate and reliable account of important information needed for their day-to-day lives (CCJ, 2006a). But a closer look at this purpose reveals there are many dimensions to journalism, including “helping define community, creating common language and common knowledge, identifying a community’s goals, heroes and villains, . . . pushing people beyond complacency[,] . . . [and] other requirements, such as being entertaining, serving as watchdog and offering voice to the voiceless” (CCJ, 2006a, ¶ 3). In fact, journalism has been likened to a form of cartography such that “it creates a map for citizens to navigate society” (CCJ, 2006a, ¶ 12). This map becomes less reliable when events are inflated for sensation, neglected, stereotyped, or disproportionately portrayed as negative (CCJ, 2006a).

To meet the primary task of providing citizens with the information they need to be free and self-governing, Kovach and Rosenstiel (2001) provide a list of nine core principles citizens have a right to expect of journalists. These principles or elements are outlined in Kovach and Rosenstiel’s (2001) *The Elements of Journalism* and are (1) journalism’s first obligation is to the truth; (2) its first loyalty is to citizens; (3) its essence is a discipline of verification; (4) its practitioners must maintain an independence from those they cover; (5) it must serve as an independent monitor of power; (6) it must provide a forum for public criticism and compromise; (7) it must strive to make the significant interesting and relevant; (8) it must keep the news comprehensive and proportional; and (9) its practitioners must be allowed to exercise their personal conscience (see Appendix C for a description of each these principles).

These elements have also been referred to as the “theory of journalism” (CCJ, 2006a), and the success of a journalist may be measured by the degree to which she puts this theory into practice:

For the journalist to succeed, he/she needs to break important stories, or at least to get stories well placed. To do this, the journalist has to meet the criteria of “the good story.” These criteria include: (1) exposing failings in the way power is exercised and (2) presenting unusual/new, relevant/important/useful information in a way that’s a pleasure to read so that it *is* read (which means the subject should be about people and the story should be presented in a way that elicits emotional responses). (M. Cobden, personal communication, February 22, 2007)

If journalists stopped scrutinizing how power is exercised over others a free press would cease to exist. As Carey (2003) explains:

Without a free press there can be no political democracy. It is equally true that without the institutions of democratic life there can be no journalism. No journalism, no democracy. And equally: no democracy, no journalism. Journalism and democracy share a common fate, for journalism is identical with or simply another name for democracy. When democracy falters, journalism falters, and when journalism goes awry, democracy goes awry. (¶ 4)

Upholding the theory of journalism is not impossible, but certainly difficult (Kovach & Rosenstiel, 2001). However, upholding these standards is particularly important for separating “successful journalism from lazy, good from bad, [and] the complete from the overly sensationalized” (Kovach & Rosenstiel, 2001, p. 154). Furthermore, upholding this theory is more likely to lead to accurate reporting and representation of Canadian health care wait times.

Rationale for the Study

News media coverage of health care waiting times is a poorly documented phenomenon (Shortt, 1998). Research into this area could provide insights as to how Canadians have reached their beliefs about waiting times and, more importantly, how to improve communication around waiting lists, including what causes them and how they may be shortened (Barer, 2006; Sanmartin, 2006).

This study is the first published to specifically explore newspaper coverage of waiting times for medical services. This study also aimed to make informed assertions about the possible implications of this news coverage on the public's knowledge of health services and Canadian health policy regarding waiting times for medical services. Keep in mind, however, that I have not aimed to realize the impact of my sample on either public policy or health literacy. Most significantly, this study will contribute to the literature by filling a current gap around how the news media — in this case, newspapers — portray health care waiting times. In particular, the proposed learning from this news media analysis extends beyond general characteristics and themes to a thoughtful discussion of the potential influence of this news coverage on behaviour, practice, and policy.

Significance of the Study

The number one health care policy issue for Canadians is timely access to care (WTA, 2005a). Given this fact, it should come as no surprise that stories about waiting times and access to health services dominate Canadian health policy newspaper stories (Hayes, in press). Public perceptions (including misperceptions) “are influenced by [news] media reporting of apparent deficiencies in the system” (Shortt, 1998, p. 25). In fact, reporting on long waiting times has the

capacity to “influence adversely public perceptions of and confidence in the health care system” (Shortt, 1998, p. 25).

The agenda-setting function of the news media is well-realized (Caburnay, Kreuter, Luke, Logan, Jacobson, Reddy, et al., 2003; Durrant, Wakefield, McLeod, Clegg-Smith, & Chapman, 2003; McCombs & Shaw, 1972). In fact, the news media are known to play an important role in determining not only what issues are on the public and political agendas, but also how the public perceives these issues (Durrant et al., 2003). In their discussion of “How People Learn from the Press,” Kovach, Rosenstiel, and the Committee of Concerned Journalists (2007) write:

Every time a newspaper lays out a front page, or a TV station puts together a broadcast, it is doing more than determining where and how stories should be played. It is in some ways expressing a theory about how people interact and learn from the news. Story slots and lengths are generally picked to reflect the many aspects of the community and the larger world, not just a narrow set of interests. And in effect, while the journalists may not think of them this way, these decisions are expressions of theories of democracy. (¶ 1)

A newspaper analysis (currently under review for publication) conducted over an eight-year period and including 13 major Canadian daily newspapers, demonstrated that the majority (approximately 66%) of health articles are about the health care system (Hayes et al., in press). Most of these articles are about health care management and regulation issues, but they are also about health care delivery and treatment, which includes stories about waiting times for medical services (Hayes et al., in press).

The same study hopes to shed insights on the significantly under-explored concept of media health literacy, which fosters the idea that media (including news media) are resources

from which individuals seek and draw health information, which contributes to their understanding and knowledge of health and health care (I. Rootman, personal communication, July 27, 2005).

The current study is particularly relevant, as the news media frequently report on waiting times — an issue that is sometimes equated with the stability of our health care system, thereby having the potential to impact all Canadians. In the past couple of years in particular, this news coverage has seemingly increased, with Canadian governments having prioritized managing waiting lists and reducing long waiting times in areas that are of most importance to Canadians, including cancer care, cardiac care, diagnostic imaging, joint replacement, and sight restoration (Health Canada, 2004a).

As important sources of information about health for the general public as well as policy and decision makers, daily newspapers are a useful resource for exploring the news media's dialogue on health care waits. In particular, daily newspapers contribute to the public discourse on health by providing a forum for opinion and debate, but also by setting an agenda for radio and television coverage (M. Cobden, personal communication, September 22, 2005).

Recent Canadian statistics indicate newspapers are a popular news source, rivalled only by television (Report Card on Canadian News Media by the Canadian Media Research Consortium, 2003; Standing Senate Committee on Transport and Communications, 2006). Although television news retains dominance, the 2005 Newspaper Audience Databank Inc. (NADbank) survey found that 51% of adults 18+ read a newspaper on the average weekday; 55% of adults 18+ read a newspaper last weekend; and 78% of adults 18+ read a newspaper in the past week. The same survey found adults spend an average of 47 minutes reading a daily newspaper on a typical weekday and nearly twice that much time (88 minutes) on the weekend

(NADbank, 2005). Consequently, newspapers are a useful resource for exploring how the news media represent health care waiting times.

Scope and Assumptions of the Study

This study aimed to explore and describe a sample of Atlantic Canada daily newspaper coverage of waiting times for medical services. In particular, this study aimed to describe the general characteristics and themes that arise from this newspaper coverage and, where appropriate, compare and contrast these characteristics and themes across newspapers in the sample. Finally, this study aimed to make informed assertions about how news coverage of waiting times can impact the public's knowledge of its health care as well as inform Canadian policy makers, who make waiting time policies.

Although this study aims to explore how the news media portray waiting times for medical services, the study sample includes newspapers as the only news media source. One basic assumption made in this study, therefore, is that newspaper coverage of waiting times for medical services will give some indication as to how the news media at large portray health care waiting times.

Another assumption I bring to this study is that I will be able to make informed assertions about the possible implications of newspaper coverage on the public's knowledge of health services and Canadian health policy regarding waiting times for medical services. This is not to say the study findings will be applicable or representative of the general Canadian population. Rather, it is through a thoughtful consideration of my findings and literature review that I have proposed to make assertions. However, in doing so, I have also assumed something about the reader and health policy — in particular, by proposing to make informed assertions about how newspaper coverage may impact public knowledge and health policy, I have assumed the public

reads and is influenced by newspaper coverage of waiting times for medical services and that health policy is influenced by newspaper coverage of waiting times for medical services, respectively.

Chapter Summary and Outline of the Remainder of the Document

Waiting times for health services are an important topic for all Canadians. At a time when patients are often referred to as consumers and expected to take a more active role in their health and health care, it is particularly important that Canadians get the information they want and need from the news media. Researchers who study waiting times suggest the information the news media provide on this subject is misleading and misinformed (see McDonald et al., 1998; Sanmartin, Barer, & Sheps, 1998). At the same time, there is no research evidence to support such claims. The current study is the first of its kind in the published literature to establish research evidence on how the news media represent health care waiting times.

In chapter two, a thorough background of important literature is presented. This literature involves a review of health care waiting times, media portrayal of health and health care, and health literacy — all of which have made important contributions to the literature and have helped in the framing of my own research questions and design. In chapter three, I revisit my contribution to literature, revealing my research methodology and design. Chapter four provides an overview of my main findings, which includes a presentation of general sample characteristics as well as the findings of my thematic analysis. As already mentioned, the study findings reveal that when it comes to news coverage of wait times for health services, the news media tend to report negative information and construct crisis. In particular, four major themes arose from this study including: (1) wait times are indicative of inadequate resources within the health care system; (2) the health care system is in a state of crisis due to long waits; (3) there is an ongoing

debate over the impact of public versus private health care on wait times; and (4) greater managed care techniques are the starting point for improving wait times, but there is confusion over which techniques are best. In chapter five, I provide a discussion of my main findings as well as make informed assertions about the implications of these findings. I finish by making general conclusions and recommendations for future research.

CHAPTER TWO: LITERATURE REVIEW

A literature review sets the context for one's work in relation to others' (Cooper, 1998).

In this chapter, I present a summary of and commentary on the empirical and theoretical literature others have conducted in areas relevant to my research. This study aims to describe the general characteristics that arise from Atlantic Canada daily newspaper coverage of waiting times for medical services and make informed assertions about how this coverage can influence the public's knowledge and Canadian health policy regarding waiting times. The areas from the literature I will explore are waiting times for medical services; media (particularly news media) portrayal of health and health care; and health literacy. This literature review shows how the contributions (as well as the absences) of the existing evidence influenced my thinking as I constructed my research questions and design.

Waiting Times for Medical Services

The issue of waiting times and waiting lists is a hot and contentious topic that has increased in prominence over the last 10 to 15 years (Kirby, 2002; Romanow, 2002; WCWL, 2001). This topic "continues to dominate the popular discussion of health care politics and policy" (McIntosh, 2006, p. 1). At the September 2006 Justice Emmett Hall Memorial Lecture in Vancouver, British Columbia, Professor John (Jack) A. Boan said "[t]here is currently a lot of chatter, both officially and on the street about wait times" (p. 3).

Although discussions tend to focus on waiting times and waiting lists, the larger issue is one of access to care, especially as this applies to medically necessary services (CIHI, 2006a). Not surprisingly, access to care is the key health care concern of governments, health system managers, health professionals, policy analysts, and the general public (Kirby, 2002; Health Canada, 2004a; McDonald et al., 1998; McIntosh, 2005; Postl, 2006; Romanow, 2002). In fact,

CHSRF (2005) has said “[f]ixing the problem with waiting times is a growing preoccupation for all Canadian governments; both federal and provincial leaders have repeatedly stated that timely access to quality health care for all Canadians is their first priority” (p. 1).

Fortunately, the data that exist on waiting times are better today than ever before (CIHI, 2006a). At the same time, CIHI (2006a) recently reported Canada is far from reaching its vision of knowing how long patients wait for different types of care and how this has changed over time; knowing how waits affect the health and well-being of patients and their families; knowing what works best to reduce waits; and having this information for all parts of a patient’s journey. However, as researchers like Rachlis (2004, 2005) report, there are ways to overcome the difficulties that long waits pose.

One of the greatest challenges — defining waits — is already the focus of much research attention, with the research funding agency CIHR having already instigated a major research push to explore what we mean by “appropriate” waiting times (Barer, 2006). In this section, I provide an overview of how waiting times and waiting lists are defined. I also present the proposed problems surrounding and solutions for improving access to care.

Defining Health Care, Waiting Times, and Waiting Lists

To situate waiting times and waiting lists in the broader context of health, I begin by defining health and health care. In the WHO constitution of 1948, health is defined as “a state of complete physical, social and mental well-being” (Ottawa Charter for Health Promotion, 1986, p. 1). In addition, health has been defined “as a resource for everyday life, not the object of living [and as] . . . a positive concept emphasizing social and personal resources as well as physical capabilities” (WHO, 1998, p. 1). This broad view of health recognizes that various factors — also referred to as determinants of health — influence the health status of individuals and

populations in a multifaceted and interactive way (WHO, 1998). The determinants of health include income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture (PHAC, 1999).

According to the WHO (1998), “Public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health related nongovernment organizations and community groups, and professional associations” are all part of the health sector or health care system (p. 12). It is within this context of health care services (a single dimension of health) the discussion of waiting times and waiting lists occurs.

Waiting times is a term with “a multiplicity of meanings” (Boan, 2006, p. 3). Over the years, many definitions of waiting times for health services have surfaced (see Appendix D for a select list of definitions of waiting times and waiting lists). But defining waiting times has long been recognized as problematic (Barer & Lewis, 2000; Hadorn, 2000; McDonald et al., 1998; Sanmartin et al., 2000). In 1998, McDonald et al. reported:

[w]ith rare exceptions, waiting lists in Canada, as in most countries, are non-standardized, capriciously organized, poorly monitored, and (according to most informed observers) in grave need of retooling. As such, most of those currently in use are at best misleading sources of data on access to care, and at worst instruments of misinformation, propaganda, and general mischief. (p. i)

In 2000, Sanmartin et al. reported that “confusion over terminology, differences in measurement approaches and a general lack of awareness of the relative effectiveness of

different approaches to managing waiting lists and waiting times all hamper real progress in this area” (p. 1305). At the same time, Barer and Lewis (2000) provided thoughtful insight as to where the problems lie in defining waits and, beyond this, how these problems lead to confusion in the news media and among the general public:

A “waiting list” for health care is a list of patients awaiting a service such as surgery or an appointment with a cardiologist. But this doesn’t tell us whether everyone who waits for a service is actually on a list, or how patients get on lists, or whether they all need to be there, or who manages the lists. It is also silent on whether physicians share lists so that patients get service through the shortest or fastest moving list. So when the Winnipeg Free Press reports that the wait list for cataract surgery in Winnipeg has 2000 patients on it, what does this tell us? Everyone can probably agree with the basic definition of a wait list. But that’s about all we’ll find agreement on in this contentious area. It is no wonder that we end up with a confusing public discussion about how long the lists are for different types of care in Canada. (p. 1)

Also at the time, Sanmartin et al. (2000) published the major sources of variability in reported waiting times. The authors cited four main sources of variability:

(1) lack of standard definitions of when waiting starts (first visit to one’s general practitioner about a particular problem; the time of the treatment decision; the time when the facility for treatment is booked; or the last consultation before one’s surgery); (2) different measures of waiting time (cross-sectional; retrospective; or prospective); (3) different statistics reported (mean waiting time; median waiting time; proportion of patients waiting a given period); and (4) variation in list management (differences among individual physicians, institutions and regions; or lack of audit. (p. 1306)

In addition to these sources of variation, waiting lists and waiting times have been conceptualized in predominantly three ways: (1) as measures of access to care (Buske, 1997; Coyte, Wright, Hawker, Bombardier, Dittus, & Paul, 1994; Daniels, 1982; Fielder, 1981; Ho, Coyte, Hawker, , & Wright, 1994); (2) as mechanisms for allocating and rationing health care services (Baker, 1994; Bloom and Fendrick, 1987; Cox, 1994; Globerman, 1991; Jacobs and Hart, 1990; Light, 1997; Naylor, 1991); and (3) as indicators of inadequate resources within the health care system (Baume, 1995; Cullis and Jones, 1983; Frankel, 1991; Goldacre et al., 1987; Mullen, 1994; Naylor, Sykora, Jaglal, & Jefferson, 1995; Sanderson, 1982).

Today, the differences in how waiting times are measured and defined are well-articulated: “First, different wait lists cover different types of patients[; s]econd, wait times can be defined differently[; and t]hird, there are also different ways to measure wait times” (CIHI, 2006a, p. 7). The recent CIHI (2006a) report, *Waiting for Health Care in Canada: What We Know and What We Don't Know*, explains the current situation in more detail:

Although work on wait times is underway across the country, there is no Canada-wide waiting list for care. Comparable data about who is waiting for what, for how long and the factors that influence waiting are more common than in the past, but still far from comprehensive. We also know relatively little about how waiting for surgery, chemotherapy or other treatment affects patient outcomes in the long term. Even within many regions and hospitals, wait lists exist in multiple places. (p. 6)

While there is much information “we don't know” about waiting times, today's definitions appear to have more clarity, especially given the recent focus on defining waiting time benchmarks for specific health care services, particularly in the areas of heart care, cancer care, joint replacement, diagnostic imaging, and sight restoration (Ministry of Health and Long-

Term Care, 2005). In late 2005, CIHR released the results of eight research syntheses as part of its “Toward Canadian Benchmarks for Health Services Wait Times: Evidence, Application and Research Priorities” request for applications (CIHR, 2005). These syntheses — covering the areas of cancer, joint replacement, and sight restoration — were intended to assist the First Ministers as they met their December 2005 milestone for establishing benchmarks (or standard waiting times) in these areas (Barer, 2006; CIHR, 2005).

As it happens, not all jurisdictions were able to meet this milestone. Fortunately, the HCC (2005) recently proposed a set of guidelines in its background report, “10 Steps to a Common Framework for Reporting on Wait Times,” to assist jurisdictions in coming up with a standard way of managing and presenting information on waiting times. According to the report, waiting times may be defined as the time from the initial patient referral to the completion of the procedure (HCC, 2005).

While recent waiting time definitions and efforts have become more focused, the controversy over how to define waiting times is expected to persist. For example, consider the debate over how the Fraser Institute — a right-wing think tank in Vancouver, British Columbia — defines waiting times. Although the institute claims it has “the only national, comparable, and comprehensive measurement of waiting times available in Canada” (N. Esmail, personal communication, June 23, 2005), there have been some long-standing issues raised regarding the methods the institute uses for measuring waits. In 1998, Sanmartin et al. (1998) argued that since the Fraser Institute depends on accuracy in physician reporting of waiting times, “if waiting times are overestimated, so too will estimates of waiting size be over-stated” (p. 297). Clearly, we have yet to reach a point where there is a common definition of (or way of measuring) waits.

Proposed Problems and Solutions

In recent years, federal, provincial, and territorial leaders have vowed to take action to reduce waiting times in areas of most concern to Canadians, but as CHSRF (2005) points out, leaders “face many conflicting suggestions on how to fix the problem” (p. 2). And as the intense reaction to the June 2005 Chaoulli decision demonstrates, not everyone agrees on how to reduce waiting times. Health Canada (2004a) has summarized some of the necessary actions to cut waits:

Shortening wait times requires having the right number and mix of professionals to more readily meet Canadians’ needs. It also means delivering care in the most appropriate setting, improved information on wait times and wait list management, better management of chronic diseases, enhanced system efficiencies, and investments in longer term initiatives that foster sustained improvements in timely access to care. (¶ 3)

This definition gets at some of the overarching beliefs about how to improve access to care.

Perhaps the most popular belief for improving access is to increase funds and resources:

For those who view waiting lists and times as either evidence of unmet needs or inadequate resources, the policy solution is fairly evident: more resources are required in the health care system to reduce or eliminate the problems associated with waits. This may be achieved by increasing the amount of funding allocated to health care, by increasing the capacity to provide services, or by considering methods of reducing the pressures on those resources within the publicly funded system. (WCWL, 2001, p. 2)

In a 1998 survey drawn from provincial ministries of health, hospitals, regional health authorities, and nongovernmental health organizations, respondents reported the two most common causes of excessive waits were inadequate resources and poor management of existing

resources (Shortt & Ford, 1998; Shortt et al., 1998). Meanwhile, the most frequently offered solution was to increase funding (in the same ways as cited by WCWL, 2001).

In the discussion on funding, increasing access to private health care is sometimes recommended. CHSRF (2001) highlights what proponents of private health care believe: “Canada is one of the last countries to resist the logical evolution to a mixed-payer system [and i]t’s only a matter of time . . . before Canada gets in and joins the rest of the crowd” (p. 1). However, the research evidence is clear — private health care will not lead to improved access (CHSRF, 2001). In fact, England and New Zealand, which have parallel private systems, appear to have longer waiting times in the public system than countries with a single-payer system, such as Canada (Tuohy, Flood, & Stabile, 2004).

Today, at least four popular myths exist around the introduction of a two-tier system. The first myth is that a “public sector monopoly causes waiting lists” (Flood, 2006). In a presentation to CHSRF in Ottawa, Ontario, the Institute of Health Services and Policy Research’s scientific director, Dr. Colleen M. Flood, said “the [Supreme] Court treats it as though Canada is the only country with wait lists, but in reality, many countries struggle with waiting lists,” as the England and New Zealand cases demonstrate (Flood, 2006). In reality, waiting lists may be medically necessary. For example, the federal wait times adviser’s report says: “waiting before surgery may be appropriate in instances where a patient must improve his/her health status to ensure the success of a procedure or, as mentioned in an earlier chapter, to make personal arrangements either before or following surgery” (Postl, 2006, p. 64).

The second myth about a two-tier system is that the “[f]reedom to purchase private insurance will reduce wait times in the public systems” (Flood, 2006). Experiences from Australia and England have found that the more care provided in the private sector, the longer

the waiting times for public hospital patients (Duckett, 2005). In fact, with the introduction of a private system, demands increase. Further to this, as Flood (2006) explains, “time spent working in the private sector is time that can’t be spent in the public system.” And whether or not physicians support spending some of their time in the private sector, most “provincial health insurance plans forbid doctors from offering services privately that they can offer under the public insurance plan” (McIntosh, 2006, p. 6), with the exception of Newfoundland and Labrador (Flood, 2006).

The third myth is the “[f]reedom to purchase private insurance will allow ‘many’ ‘ordinary’ people access to timely treatment” (Flood, 2006). In countries such as Sweden, Germany, and the United Kingdom (U.K.), the reality is only a small minority is able to purchase private insurance, even though it is available for everyone to purchase.

And the fourth myth, “[i]nternational experience shows that allowing two-tier [health care] will have no detrimental effect on the public system” (Flood, 2006). The main issue with this myth is that European systems are not two-tier, but group-based (Flood, 2006). Take the Dutch system for example: the poorer 60% pay a portion of their salary to public insurance (like medicare), while the top 40% must purchase private insurance, as they are ineligible for public insurance (Flood, 2006). In this way, no one can “double up” on insurance (Flood, 2006). In Canada, there is no talk of de-insuring people (Flood, 2006). Rather, the idea is that everyone would maintain universal coverage and have the “choice” of purchasing additional private insurance (Flood, 2006). As CHSRF (2001) explains, this kind of thinking is not beneficial for the common good: “A parallel private system can provide faster care — to those with deeper pockets” (p. 2).

Another popular belief about how to improve access to care and reduce waiting times is through better management techniques: “For those who view waiting lists as mechanisms to allocate services, policy options focus on ensuring that waiting lists are properly managed and patients are appropriately prioritized to ensure equitable access to services and reduced adverse effects” (WCWL, 2001, p. 2). In a recent interview with *Macleans*, the federal wait times advisor, Dr. Brian Postl, steered the conversation toward a focus on managed care:

I think the issue around wait lists is more an issue of how we manage within the system than it is a public-private debate. If, in the end, it becomes evident that we can effectively add capacity and efficiency through some private partnerships, I think that becomes an issue of how do you add capacity, and I think the private sector is one vehicle. (Geddes, 2005a, ¶ 5)

Nowadays, lack of coordination and audit are well-recognized as the underlying problems of long waits. These problems, as Sanmartin et al. established in 2000, can be addressed through various management techniques, including reducing demand (list-clearing initiatives such as list audits and reassessment of patients on the list); prioritization of patients on the list (improved list coordination by, for example, matching place in queue with clinical urgency); and reorganizing patterns of care (methods to reduce missed appointments; redirection of referrals to clinicians with shorter lists; and reduction of specialist physician follow-up) (p. 1308).

And there are other management techniques. Another prioritization technique, for example, is to enforce guaranteed maximum wait programs, where patients who are approaching a maximum time threshold are given priority over other patients (Hanning, 1996; Sanmartin et al., 2000). Also in terms of prioritization, there is a push to use priority-setting scoring systems (Noseworthy et al., 2003; Noseworthy & McGurran, 2004). In terms of reorganizing patterns of

care, some also talk about managing waiting lists centrally (by province, health region, or institution) and for a particular kind of care (CHSRF, 2005).

In addition to the popular solutions related to management and funding, other options to reduce waiting times include (1) launching health human resources initiatives (for example, increasing enrolment to health care professional programs and increasing uptake of international medical graduates); (2) making waiting list information publicly available to facilitate coordination; (3) enhancing homecare initiatives; (4) introducing new technologies in rural and remote care; (5) collaborating with international partners; and (6) encouraging the public to engage in health prevention and promotion activities to decrease demand on health care services.

News Media Portrayal of Health and Health Care

There are many proposed solutions for fixing long health care waits. Since the news media play a key role in determining what issues make it to the public and political agendas (Durrant et al., 2003), some of these solutions may gain greater news media coverage than others. In this section, I define the terms mass media and news media, journalist and reporter. I then provide an overview of how health news is framed and sometimes sensationalized. I also provide insights from the literature around the agenda-setting function of the news media — particularly, the impact of health news on behaviour, practice, and policy. Finally, I discuss the barriers and facilitators reporters cite when covering health and health care news.

Defining Journalism and the News Media

The news media, a specific subset of the mass media, encompass all types of media designed to reach a large audience: print (newspapers and magazines); broadcast (radio and television); and Internet-based news media. Most studies in this review draw their sample from

newspapers, as newspapers provide access to textual data, which facilitates textual analysis techniques such as content and discourse analyses (Altheide, 1987), as I will explain in chapter three.

In “Notes Towards a Definition of Journalism,” Adam (1993) defines journalism as “an invention or a form of expression used to report and comment in the public [news] media on the events and ideas of the here and now” (p. 11). A more in-depth view of journalism describes it as “storytelling with a purpose:”

It should do more than gather an audience or catalogue the important. For its own survival, it must balance what readers know they want with what they cannot anticipate but need. In short, it must strive to make the significant interesting and relevant. The effectiveness of a piece of journalism is measured both by how much a work engages its audience and enlightens it. This means journalists must continually ask what information has most value to citizens and in what form. While journalism should reach beyond such topics as government and public safety, a journalism overwhelmed by trivia and false significance ultimately engenders a trivial society. (CCJ, 2006a, ¶ 11)

At a more basic level, journalism is the profession or practice of reporting about, photographing, or editing news stories. A journalist, therefore, is someone who reports, photographs, or edits news stories. A reporter is a more specific title for those who gather facts (for example, by interviewing sources) for the stories they are assigned to write (Saskatchewan Education, 1998).

Mass media studies are now commonly divided into three broad areas of inquiry: production, representation, and reception studies (Seale, 2003). Seale (2003) defines studies of production as being concerned with “the manner in which media producers behave” (p. 515).

Contrarily, studies of representation involve “analysis of media messages themselves” (p. 515). Finally, studies of reception entail “investigations of media audiences” (p. 516). The most common kind of media studies are studies of representations (Seale, 2003). Media studies that focus on analysing media messages “may seek for ideological biases, or the discursive dominance of particular themes and constructions, or be concerned with whether messages are likely to promote or damage health” (Seale, 2003, p. 515). This review captures mostly representation studies that analyse how the news media represent health and health care. Some of the studies herein are reception studies, as the authors analyse how health news media messaging is received and, more specifically, how these messages directly or indirectly impact patient behaviour, health care services utilization, health care provider practice, and public policy.

Framing, Sensationalism, Inaccuracy, and Fear in Health News

The process by which the news media present and package news stories is referred to as framing (Durrant et al., 2003). Durrant et al. (2003) define framing as “what problems are seen as being important . . . what their causes are, and what their solutions might be” (p. 75). In this way, the authors consider news as more of a “‘social construction’ than a direct transfer of facts to the public” (p. 75). In journalism, this framing has been called “invention,” “creation,” and “a product of the imagination,” such that journalists, acting like artists, frame experiences and form the public consciousness (Adam, 1993, p. 13). This is not to say that journalists distort reality, however that may be defined; rather this view recognizes journalism as a form of art and expression, wherein journalists are the artists (Adam, 1993). In some of the literature on creativity in history and biography, creativity is understood as giving the product “artistic shape” (Tuchman, 1982, p. 80 as cited in McKercher and Cumming, 1998, p. 107).

One of the ways journalists may frame an issue is through the use of metaphors. Van Dijk (as cited in Peterson, 2001) has said “the choice of metaphors is always strategic, and scientists as well as journalists have always been keenly aware of the impact of metaphors on the public’s understanding of science” (p. 1257). In news media reports of the human genome, for example, popular metaphors have included images of a “puzzle,” “riddle,” “code,” “book,” or “map” (Peterson, 2001, p. 1261). Wallis and Nerlich (2005) explored the use of metaphors in news media descriptions of new epidemics — particularly the U.K. news media framing of the 2003 Severe Acute Respiratory Syndrome (SARS) epidemic. Although usually “war” and “plague” metaphors dominate “control of disease” discourse, the metaphors in the U.K. news media focused on “killer” and “control” metaphors (Wallis & Nerlich, 2005, p. 2630). These kinds of metaphors can be likened to “newsspeak” or language that distorts, confuses, or hides reality (Saskatchewan Education, 1998). Such metaphors may also serve to sensationalize the news, generating false fears and anxieties.

A long-standing complaint of researchers is that journalists “sensationalize their findings, thus introducing inaccuracies” (Nelkin, 1995). A health news story is said to have become “sensationalized” when journalists overstate the details (such as scientific findings), which can in turn lead to the public being misled about the implications of the issues (Shuchman & Wilkes, 1997). These overstatements are sometimes referred to as “tabloidization” (Sparks & Tulloch, 2000) — an appropriate term given Seale’s (2003) point:

People do not make TV programmes or publish newspapers solely in order to provide the public with accurate health information. The entertainment agenda (and this applies to news and current affairs as much, probably, as it does to “fictional” products) is more

dominant, and scientists, medical care providers and health educators have increasingly come to recognize this. (p. 519)

However, according to Kovach and Rosenstiel (2001), “attracting audiences by being merely engaging will fail as a business strategy for journalism over the long term” (p. 154). The authors give three reasons why the news media must offer more than “infotainment” if they hope to have a sustained existence: first, “if you feed people only trivia and entertainment, you will wither the appetite and expectations of some people for anything else;” second, “it destroys the news organization’s authority to deliver more serious news and drives away those audiences who want it;” and third, “when you turn your news into entertainment, you are playing to the strengths of other media rather than your own” (Kovach & Rosenstiel, 2001, p. 154). Kovach and Rosenstiel (2001) are clear that news is different from entertainment, arguing the value and allure of news is fundamentally different from entertainment: while news is based on relevance and substance, infotainment is based on form (Kovach & Rosenstiel, 2001).

With that said, news media representation studies (and other resources about news coverage) of new prescription drugs demonstrate how the news media can sometimes sensationalize story details and, in the process, mislead and misinform their audiences (Cassels, Hughes, Cole, Mintzes, Lexchin, & McCormack, 2003a; 2003b; Moynihan & Cassels, 2005; Moynihan, Bero, Ross-Degnan, Henry, Lee, Watkins, et al., 2000; Moynihan, Heath, & Henry, 2002). Researchers in Canada and elsewhere have found news reporting of new drugs captures drugs as “miracle cures,” all the while understating drug harms, indications, contraindications, and costs (Cassels et al., 2003a; 2003b; Moynihan et al., 2000). Anhang et al. (2003) found news media coverage of human papillomavirus (HPV) also lacked important details, as “many stories failed to include basic information that women express interest in knowing, and many presented

facts without important caveats or nuances that may impact women's perceived susceptibility to HPV and anxiety levels about the virus" (p. 311). These particular findings illustrate two points common to news media analysis studies: first, health news often misses important information about health conditions or preventive interventions (Caburnay et al., 2003; Stryker et al., 2005; Wilson, Code, Dornan, Ahmad, Hébert, & Graham, 2004; Wells, Marshall, Crawley, & Dickerson, 2001); and second, health news frames risk and disease information in such a way that it instils fear and anxiety in readers (Shuchman & Wilkes, 1997; Wells et al., 2001).

Early media representation literature has found the mass media provide distorted representations (including under-representation) of women and minority groups (Tuchman, 1979). However, as Shuchman and Wilkes (1997) explain, while inaccurate political or business news reporting can jeopardize reputations, misleading health or medical reporting can lead to false hopes and unwarranted fears. A September 2005 *Maclean's* article, "Forget SARS, West Nile, Ebola and Avian Flu. The Real Epidemic is Fear" hit this nail on the head (George, 2005). In this popular Canadian weekly magazine, the reporter writes "[w]e keep bracing ourselves for one cataclysmic threat after another. Our perceived lack of safety has become an obsession" (George, 2005, ¶ 1). Seale (2003) speaks of fear in his description of the five key elements that run through contemporary mass media health representations. These elements (which are the premise of many news media health stories) are (1) the dangers of modern life; (2) villains and freaks; (3) victimhood; (4) professional heroes; and (5) lay heroes. The collections of stories that refer to the dangers of modern life are those that generate unwarranted fears (Seale, 2003): "In a variety of ways," writes Seale (2003), "mass media emphasize the dangers of modern life," thereby "generating a climate of insecurity" (Seale, 2003, p. 521).

Even in instances when some anxiety may be warranted, the news media can (arguably) go too far. For example, in a study on cancer in the mass print news media, Clarke and Everest (2006) found that cancer is framed in terms of extreme fear and dread, with reporters using such phrases as “the dreaded C word,” “the nightmare of cancer diagnosis,” “life beyond the terror,” and “every women’s greatest fear” (p. 2595).

What is important to remember is that such “[m]ass media depictions, of course, are not ‘true’” (Seale, 2003, p. 514). Instead, news media stories can only ever be close or partial versions of the truth at given points in time (Seale, 2003). In *The Elements of Journalism*, Kovach and Rosenstiel (2001) say truth is “the first and most confusing principle” (p. 36) but also what sets journalism apart from all other forms of communication:

. . . there is little doubt that journalists believe themselves to be engaged in pursuing truth — not just free speech or commerce. We have to be. For this is what society requires of us. And, as we will see, this “journalistic truth” — is also more than mere accuracy. It is a sorting-out process that develops between the initial story and the interaction among the public, newsmakers, and journalists over time. This first principle of journalism — its disinterested pursuit of truth — is ultimately what sets it apart from all other forms of communications. (p. 41-42)

Rather than truth in its purest sense, journalists seek functional or practical truth (Kovach & Rosenstiel, 2001). As a result, journalists often engage their audiences in ongoing narratives, made up of several smaller stories that unravel over time and tell pieces of the larger truth (Kovach & Rosenstiel, 2001).

While journalists have an obligation to the truth (Kovach & Rosenstiel, 2001), the news media at large do not. In fact, news media audiences must remember that “producers of mass

mediated messages about health have particular agendas, and this is likely to influence what is shown” (Seale, 2003, p. 514). In the same way, the news media “[do] not, as it is so often said, provide citizens simply with the news they want[;] . . . they also get the news that Wall Street, ownership, journalism training, and the conventions of news dictate be made available to them” (Kovach and Rosenstiel, 2001, p. 191).

Impact of Health News on Behaviour, Practice, and Policy

The news media are well-recognized as playing a powerful and influential role in the social environment (Caburnay et al., 2003). In particular, this power and influence is commonly referred to in terms of the “agenda-setting function” of the news media (Caburnay et al., 2003; Durrant et al., 2003; McCombs & Shaw, 1972). Durrant et al. (2003) explain “[t]hrough the selection of particular news stories, certain issues are given more salience, whereas others are deemed less newsworthy” (p. 75). As a discussion on framing reveals, the news media play an important role in determining not only what issues are on the public and political agendas, but also how the public perceives these issues (Durrant et al., 2003). In this section, I provide insights as to the kinds of topics for which the health news media appear to have a preference. I also discuss the various impacts of health news coverage.

Although (in many cases) there are specialized reporters who report on health and medical news, Shuchman and Wilkes (2003) argue medical and health care issues that are deemed to be important by researchers continue to be ignored by the news media. One explanation the authors suggest is that journalists have a narrow scope of health (Shuchman & Wilkes, 2003). Research evidence on news coverage finds this explanation to be reasonable. In a study of the portrayal of health in 13 major Canadian newspapers, for example, Hayes et al. (in press) found some health topics gain greater news media time than others: of the stories that

made an explicit connection to health, Hayes et al. (in press) found the majority of these were about the health care system — mostly about health care management and regulation issues, but also health care delivery and treatment (Hayes et al., in press). The remaining stories focused on the physical environment (including stories relating to pollution and natural hazards, for example), followed by stories about the socioeconomic environment, early childhood development, and personal health practices (Hayes et al., in press). Caburnay et al. (2003) found similar findings — particularly that news coverage of health behaviours (including diet, physical activity, and tobacco) is lacking. On the one hand, these examples seem to imply journalists have a narrow scope of health; on the other hand, it could mean journalists look at health through the prism of “the good story.”

In their content analysis of news coverage of skin cancer prevention and detection in the Associated Press, Stryker et al. (2005) found that nearly 70% of the skin cancer stories in their sample were reports of new research or celebrity experiences with skin cancer. This finding highlights that new research can often be taken at face value in the news media, without the necessary scrutiny it deserves. When the news media do report on research, it is often only single-study findings that are shared (Johnson, 1998). Seale (2003) asserts it is in the news media’s best interests to refrain from providing more precise details of research findings since “popular mass media would cease to be popular if complexity were represented in a way that a scientist would find acceptable in a scientific journal” (p. 519). When it comes to research, says Seale (2003), “[s]ome degree of simplification must be necessary if the dramatic oppositions that are the core device of story telling are to be created” (p. 514).

Instead of relying on research evidence, the news media most often report on anecdotal evidence, which is considered “the lowest rung of the evidentiary ladder in science” (Johnson, 1998, p. 91). Mullen (1999) further discusses this focus on anecdotes:

Terms such as “evidence-based” and “data-driven” are the coin of the policy world today, and “the anecdote” as evidence is as much demeaned in policy circles as it is in clinical medicine. Yet, important as the arguments are for the use of quantitative science to inform clinical and policy, the anecdote — the report of life events from an unabashedly subjective vantage point — remains a powerful tool for focusing the human mind.

It would seem “[f]ew parts of the human world are better suited to storytelling than healthcare” (CHSRF, 2003, p. ii). And often, a few common narratives emerge, including the story of the “patient fighting for her life, with the courage to rise against what appear to be overwhelming odds” (CHSRF, 2003, p. ii). Seale (2003) argues depictions of sick children are among the most effective victim portrayals in contemporary media. In “Once upon a time. . . The use and abuse of storytelling and anecdote in the health sector,” the author explains the appeal of anecdotes in health care: “the narrative is so appealing because it is familiar and thus comfortable, like an old pair of slippers” (CHSRF, 2003, p. 3). And arguably, those who live the health experience are experts on their own situation (Seale, 2003).

Whether through the use of anecdote or other forms of evidence, the news media help “to create the unarticulated assumptions and fundamental beliefs that underlie personal decisions, public policies, and clinical practices” (Nelkin, 1996, p. 1602). The agenda-setting theory of the news media is particularly important to discussions of health news coverage, as current research indicates health news influences health behaviour and health services utilization (Grilli, Ramsey, & Minozzi, 2002; Snyder, Hamilton, Mitchell, Kiwanuka-Tondo, Fleming-Milici, & Proctor,

2004). The World Health Organization (1998) explains how health promotion material (including that which is disseminated by the news media) can lead to items reaching a policy agenda or challenging individual health decision-making:

Much of modern culture is transmitted by the mass and multi media which has both positive and negative implications for health. Research shows that theory-driven mediated health promotion programming can put health on the public agenda, reinforce health messages, stimulate people to seek further information, and in some instances, bring about sustained healthy lifestyles. (p. 8)

Seale (2003) also offers important insights here:

When people get sick, or make decisions about health, or visit their health service providers, or decide what to think and vote about health care policy and finance, their behaviour may be formulated in large part from resources drawn from various mass media. These can include depictions of what it is like to be sick, what causes illness, health and cure, how health care providers behave (or ought to) and the nature of health policies and their impact. (p. 514)

Four commonly cited news media effects on their audiences are informing audiences, agenda-setting, framing, and persuading (Collins, Abelson, Pyman, & Lavis, 2006). In terms of informing audiences, research indicates the public gets much of its health and medical information from the news media (Entwistle, 1995; Johnson, 1998; Nelkin, 1996; Phillips, Kanter, Bednarczyk, & Tastad, 1991). In fact, physicians sometimes find out about new developments and initiatives in medicine through the news media (Smith, Wilson, & Henry, 2005). In Collins et al. (2006), the authors found that while the content of the news media

appeared to have the capacity to inform the public and act as conduits for policy agendas, by and large, the content was too general to lead to any real changes.

The research evidence further suggests health reporting impacts individual health practices (Grilli et al., 2002; Haas, Kaplan, Gerstenberger, & Kerlikowske, 2004; Sharma, Dowd, Swanson, Slaughter, & Simon, 2003). In a 2002 Cochrane Review, Grilli et al. (2002) reviewed studies evaluating health care utilization before and after media coverage of specific events. The researchers found favourable publicity of an event was associated with higher use in health care utilization, while unfavourable publicity was associated with lower use (Grilli et al., 2002). Haas et al. (2004) found similar results for women receiving hormone replacement therapy (HRT) following major news media coverage of findings from the Women's Health Initiative (WHI) — a randomized trial that examined the efficacy of HRT. The researchers found that the peak in news media coverage coincided with a one-third decrease in the proportion of women at a San Francisco mammography registry receiving HRT (Haas et al., 2004). Similarly, Lawton, Rose, McLeod, & Dowell (2003) found that after the publication of the results of the HRT trial, there was a substantial change in HRT use among the women surveyed, with 58% initially stopping their therapy. Meanwhile, Sharma et al. (2003) found a sizeable increase in testing for streptococci (*Streptococcus pyogenes*), commonly referred to as “the flesh-eating bacteria,” in a pediatric emergency hospital at the same time that news media coverage on the topic was at its pinnacle.

News media coverage can impact on such things as pharmaceutical sales too, as Nelkin (1996) demonstrates with two recent examples:

After a prominent cover story in *Newsweek*, the drug[, Prozac,] became a star, being covered in talk shows, magazines, and news reports as the “feel good” drug. The result

was an enormous increase in Prozac sales. Likewise, after the news media reported on Retin-A (tretinoin) as a medical treatment for skin ageing (quoting [an American Medical Association Journal] editorial), the stock of Johnson and Johnson increased by 8 points in 2 days. (p. 1602)

Since the health news media have the ability to impact behaviour, practice, and policy, reporters who cover the health beat ought to demonstrate caution. Sadly, some of the sensationalism and misinformation in the health news media are tied to the everyday challenges reporters encounter while on the job.

Barriers and Facilitators for Journalists Producing Health News

As this quote from McKercher and Cumming (1998) demonstrates, journalists face countless challenges:

There must be few jobs in which the challenges are so varied and the process of learning so central. Consider: journalists are constantly seeking to find things out. They deal with people who normally know more about the topic than they do. They have to stretch their minds to brief themselves before interviews. They have to stretch their mind to understand what they're being told. And they must understand. It's never open to journalists to let information pass over their heads. (p. v-vi)

There is considerable research focusing on the barriers journalists face in reporting on health (Johnson, 1998; Larsson, Oxman, Carling, & Herrin, 2003; Schwartz & Woloshin, 2004; Wilson et al., 2004; Winsten, 1985). Using a survey instrument, focus groups, and semi-structured interviews with medical journalists from 37 countries, Larsson et al. (2003) found medical journalists face the following kinds of challenges: (1) the influence of editors on what gets in and what is left out of stories; (2) problems finding reliable sources who are willing to

speak on the record; (3) difficulty translating scientific terminology and understanding the impact of study findings; (4) competition among news media to hold the audience; (5) competition and lack of news space (such as print space in a newspaper); and (6) lack of time to compile a story. Another potential barrier is the lack of specialized journalists and the lower numbers of reporters overall staffing news outlets (Finn, 2005).

Meanwhile, other researchers have found reporters sometimes lack critical appraisal skills (Entwistle, 1995; Larsson et al., 1993; Nelkin, 1996; Wilson et al., 2004). This was one of the main findings of a survey of 165 reporters in five Midwest states in the United States (U.S.) carried out by Voss (2002). According to the survey, only 31% and 9.7%, respectively, felt “very confident” in reporting health news and interpreting health statistics (Voss, 2002). And Kovach and Rosenstiel (2001) contend that when it comes to continuing education, “[h]airdressers have more continuing education than journalists” (p.155). This fact creates a barrier for journalists in that successful journalists are “usually self taught, learned by trial and error or, secondarily, by borrowing ideas on their own from peers” (Kovach & Rosenstiel, 2001, p. 155).

Among some of the strategies medical journalists identified in Larsson et al. (2003) as having facilitated their work include having (1) access to background material on the Internet; (2) help accessing experts and sources; (3) help developing strategies for presenting research findings; and (4) opportunities to attend critical appraisal workshops. Cope (2003) suggests that two journalistic instincts, “health skepticism (sic) and good questioning,” also “come in handy” when one is on the health or medical beat (p. 64).

Health Literacy

Health literacy is a relatively new concept. In fact, it is only within the last decade that researchers have begun to recognize the role health literacy plays “in an individual’s ability to

comprehend health and self-care information, and its relationship to health outcomes” (Speros, 2005, p. 633). Although once narrowly defined as “the ability to read and comprehend written medical information and instructions” (Coulter & Ellins, 2006, p. 22), this term is now commonly understood as a range of competencies, including “basic health knowledge; reading, comprehending and evaluating health information; application of health preventing, promoting and self-care behaviours; verbal communication with health professionals; health decision-making; and health advocacy and activism” (Kickbusch, 2001, p. 294).

Health literacy is an important topic, as Parker and Gazmararian (2003) explain:

“Informed patients not only have better outcomes, but they also truly communicate with those who provide health services [and] [t]hey are able to seek information on the Web, critically read and understand news, and place newsworthy health studies in context” (p. 117). Coulter and Ellins (2006) further this point: “[i]f individuals do not have the capacity to obtain, process and understand basic health information, they will not be able to look after themselves effectively or make appropriate health decisions” (p. 21). The American Medical Association suggests health literacy is a stronger predictor of health status than age, income, education, employment status, race, or ethnic group (Ad Hoc Committee on Health Literacy, 1999). The concept of health literacy is also important for those who disseminate health information, as notions of health literacy beg the question: “If health communication is not understood, is it truly communicated?” (Parker & Gazmararian, 2003, p. 117)

At some point in our lives, “[w]e all encounter situations where we must depend on our health literacy skills to find, understand and act upon health information and advice” (Gillis, 2005, ¶ 17). Some of these times, it is expected that we will feel limited in our understanding of information related to our health, regardless of our level of education or our literacy level (Gillis,

2005). “Health,” which Kickbusch (2001) refers to as a “societal system,” has become “increasingly complex in all its components, and requires a wide range of knowledge and skills to respond adequately in times of illness” (p. 294). And, health literacy problems are easily magnified, as patients take on a more active role in their health and health care in an increasingly complex and technologically sophisticated system (Parker & Gazmararian, 2003, p. 116).

Some individuals may encounter more problems with understanding health information than others. For example, those in the Atlantic provinces — where there exist the highest rates of low-literacy in the country (Statistics Canada, 2003a) — may encounter additional challenges when it comes to understanding complex materials that are relevant for understanding one’s health or health care (Gillis, 2005). Although there is no straightforward correlation between health literacy and such socioeconomic factors as education, the evidence indicates low health literacy is more prevalent among lower socioeconomic groups, ethnic minorities, the elderly, and those with chronic conditions and disabilities (Andrus & Roth, 2002; Sihota & Lennard, 2004). With that said, there is little research on the prevalence of low health literacy (Coulter & Ellins, 2006), with estimates in the United States suggesting the problem is significant, affecting around 90 million adults in that country (Ad Hoc Committee on Health Literacy, 1999). A recent review suggests “there is a clear need for more research into the prevalence of low health literacy and its effects” (Coulter & Ellins, 2006, p. 21).

In this section, I provide an overview of the terms literacy and health literacy and an introduction to media health literacy. I then discuss the potential links between media health literacy and the news media.

Defining Literacy and Health Literacy

The authors of the 1992 National Adult Literacy Survey in the U.S. defined literacy as “using printed and written information to function in society, to achieve one’s goals, and to develop one’s knowledge and potential” (Kirsch, Jungblut, Jenkins, & Kolstad, 1993, p. 2). Nowadays, the discussion has moved away from a naive understanding of literacy as the ability to read, write, and carry out arithmetic and toward an understanding of “literacies;” that is, “a variety of skills needed for an adult to function in society” (Kickbusch, 2001, p. 292). The Centre for Literacy of Quebec (2000) provides a working definition of literacy that recognizes the link between literacy and culture:

Literacy is a complex set of abilities needed to understand and use the dominant symbol systems of a culture — alphabets, numbers, visual icons — for personal and community development. The nature of these abilities, and the demand for them, vary from one context to another.

In a technological society, literacy extends beyond the functional skills of reading, writing, speaking and listening to include multiple literacies such as visual, media and information literacy. These new literacies focus on an individual’s capacity to use and make critical judgements about the information they encounter on a daily basis. (¶ 1)

This definition of literacy may be likened to that of health in that “[j]ust as a broader, more modern concept of health includes physical, mental and social well-being, a broader understanding of literacy includes a range of skills to navigate and apply knowledge” (Kickbusch, 2001, p. 294). Meanwhile, the Canadian Education Research Information System (1999) identifies six such skills (or literacies): quantitative literacy, scientific literacy,

technological literacy, cultural literacy, media literacy, and computer literacy. Kickbusch (2001) has lobbied for adding health literacy to this list, so it would be included on the policy agenda.

Health literacy is a new concept that links an individual's level of literacy with his ability to act upon health information (Gillis, 2005). Furthermore, this term establishes health and literacy as critical resources for everyday living (Gillis, 2005). The term health literacy was first used in a 1974 paper discussing the impact of health education on health care and educational systems as well as mass communication (Simonds, 1974). Although many definitions of health literacy exist today (see Appendix E), three definitions appear most extensively in the literature. These definitions come from the American Medical Association, the U.S. Department of Health and Human Services, and the World Health Organization. The Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs of the American Medical Association (1998) defines the term from a broad, skills-based view, as "a constellation of skills, including the ability to perform basic reading and numerical skills required to function in the health care environment" (p. 553). Meanwhile, in "Healthy People 2010," the Office of Disease Prevention and Health Promotion of the U.S. Department of Health and Human Services defines health literacy as the capacity to obtain, interpret and understand basic health information and services and the competence to use such information and services to enhance health. This definition links health literacy to health promotion and prevention. Similarly, the World Health Organization's (1998) definition of health literacy links the term to health promotion. In the "Health Promotion Glossary" — and elsewhere by Nutbeam (1998) — health literacy is defined as representing "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" (p. 10).

Although not a widely used definition, Atlantic Canadian researchers Gillis and Quigley (2004a; 2004b) provide a succinct (and my preferred) definition of health literacy as addressing how people (1) understand and use health information; (2) access suitable health services; (3) make knowledgeable health decisions; and (4) gain control over their health and well-being.

The Link between Health Literacy and the News Media

Media health literacy is also a new concept that fosters the idea that media (including news media) are a resource from which individuals seek and draw health information, which contributes to health literacy (I. Rootman, personal communication, July 27, 2005). Currently, Canadian researcher Michael Hayes is working on a research project that, in part, aims to explore this term in greater depth (Rootman, 2005). For now, the literature on media health literacy is significantly under-explored. Based on the elements of journalism, we know that citizens should have high expectations of the news media, including truthfulness; proof that the journalists' first loyalty is to citizens; that journalists maintain independence from those they cover; that journalists will monitor power and give voice to the voiceless; a forum for public criticism and problem solving; and news that is proportional and relevant (CCJ, 2007). The definition the World Health Organization uses for health communication also provides some insight:

Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of the mass and multimedia and other technological innovations to disseminate useful health information to the public, increases awareness of specific aspects of individual and collective health as well as importance of health in development. (WHO, 1998, p. 8)

Meanwhile, Proffitt (2007) argues “citizens need to be able to make informed decisions based on freely accessible and diverse information that is open to discussion and criticism [and t]he media are the primary vehicles through which this knowledge is disseminated” (p. 65).

But media health literacy extends beyond the dissemination of health information in the media and involves a more precise understanding of an individual’s uptake of media health information and the ability of the individual to gauge the value of and use this information (in their health decision-making, for example). Seale (2003) argues the onus is on the audiences of media health information to decide how (or whether) they use such information: “As ordinary people we must decide to trust or distrust media messages in much the same way as we decide to trust or distrust medical advice or other expertise” (p. 514). The ability to effectively and appropriately navigate through media health information with a healthy dose of scepticism may be considered reflective of strong media health literacy skills.

Chapter Summary

The issues of waiting times and waiting lists and the larger issue of access to care remain a high priority on the public and political agenda. However, when it comes to reporting on health and health care, the news media sometimes sensationalize, mislead, and instil fear. At a time when health literacy is rising in profile, a consideration of how health news media may impact behaviour, practice, and policy is particularly timely. Given its popularity and the news media’s track record in covering health and health care, an investigation of how the news media portray waiting times is a similarly fitting topic for investigation. In chapter three, I provide insights as to the methodology and methods I employed for my media representation study.

CHAPTER THREE: METHODOLOGY AND METHODS

An integral part of research is informing one's audience of the process undertaken to achieve the findings. Crotty (1998) explains that "we [researchers] need to lay out the process for the scrutiny of the observer; we need to defend that process as a form of human inquiry that should be taken seriously" (p. 13). To demonstrate transparency to one's audience, one must report answers to the following questions: What methods do we propose to use? What methodology governs our choice and use of methods? What theoretical perspective lies behind the methodology in question? What epistemology informs this theoretical perspective? In this section, I respond to these questions as they informed my investigation of how Atlantic Canada daily newspapers portray waiting times for medical services.

Epistemology and Theoretical Underpinnings

The primary epistemology that informs my theoretical perspective is social constructionism. Crotty (1998) defines social constructionism as "the view that all knowledge . . . is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed within an essentially social context" (p. 42). From this perspective, meaning is not discovered but constructed. In my study, a social constructionist approach is appropriate such that the meaning that is constructed is made possible through my engagement with the realities of the world; that is, through my engagement with newspaper documents. As I will outline in the next section, however, elements of positivism associated with a quantitative approach are also integral to my research design.

Methodology

In this section I outline the methodology governing my choice and use of methods, specifically, my textual analysis of newspaper documents. Fierke (2004) explains methodology as including both ontology and epistemology and referring “to those basic assumptions about the world we study, which are prior to the specific techniques adopted by the . . . research” (p. 36). In my research, I made use of quantitative and qualitative content analysis.

In the strictest sense, (quantitative) content analysis adopts a positivistic approach to textual analysis such that it is primarily concerned with being objective and systematic (Hardy, Harley, & Phillips, 2004). In addition, quantitative data are valued for their rendering of broad numerical trends and patterns in large samples or populations. The fundamental activity of this traditionally deductive methodology is hypothesis-testing using statistical analysis (Schwandt, 2001). Quantitative content analysis has become a common methodology for guiding textual analysis of newspaper documents (Anhang et al., 2003; Caburnay et al., 2003; Cassels et al., 2003a; 2003b; Davidson & Wallack, 2004; Durrant et al., 2003; Lima & Siegal, 1999; Moynihan et al., 2000; Stryker, Solky, & Emmons, 2005; Wells et al., 2001; Wilson et al., 2004). Studies that employ this traditional, positivistic content analysis approach involve “the development of analytical categories that are used to construct a coding frame that is then applied to the textual data” (Hardy et al., 2004, p. 20).

The move from a quantitative, positivistic-type of content analysis to a qualitative, constructionist-type is a move from “simple counting to more complex interpretation” (Hardy et al., 2004). Increasingly, researchers are using qualitative textual analysis techniques, including discourse and qualitative content analysis, for news media studies (Clarke, Friedman, & Hoffman-Goetz, 2005; Donelle, Hoffman-Goetz, & Clarke, 2004; Gazso, 2004; Joffe &

Haarhoff, 2002; Lupton & Mclean, 1998; Lupton, 1995; Peterson, 2001; Wallis & Nerlich, 2005). For example, in Wallis and Nerlich's (2005) analysis of SARS news coverage in five U.K. daily newspapers, the authors used a qualitative approach, as they found traditional quantitative approaches largely "inadequate for dealing with metaphor chains and the overlapping imagery common in the coverage" (p. 2631). In another example, Clarke et al. (2005) used qualitative content analysis to guide their study of the portrayal of HIV/AIDS in 14 mass print newspapers. Using a qualitative content analysis approach, the researchers examined both manifest ("that which is explicitly stated") and latent ("less obvious and includes such things as absences of themes and the deeper and perhaps unintended themes") meanings of the newspaper texts (Clarke et al., 2005, p. 2172).

In terms of the differences between quantitative and qualitative content analysis, Altheide (1987) explains that while quantitative content analysis "provides a way of obtaining data to measure the frequency and variety of messages" (p. 66), qualitative (in this case, Altheide refers to the qualitative subset, ethnographic) content analysis, "is used to document and understand the communication of meaning, as well as to verify theoretical relationships" (p. 68). The distinguishing characteristic of qualitative content analysis then, says Altheide (1987), is "the reflexive and highly interactive nature of the investigator, concepts, data collection and analysis" (p. 68). (See Appendix F for an adapted version of Altheide's (1987) table summarizing the differences between traditional and qualitative content analysis.)

Although quantitative and qualitative versions of content analysis differ, some researchers point out how using both methodologies can be complementary (Hardy et al., 2004; Neuendorf, 2004). For example, McCracken (1988) and Morse (1994) encourage qualitative researchers to employ quantitative methods to answer specific questions and add rigour to their

work. And Neuendorf (2004) argues qualitative research can add “conceptual definitions derived from reflexive process[es]” to a quantitative study, while “quantitative evidence on the prevalence and patterns of message[s]” can add important findings to one’s qualitative findings (p. 35). With that said, few studies in the research I consulted combined traditional content analysis with qualitative analysis (see Donelle et al., 2004; Lupton, 1995; Miller, Wiley, Fung, & Liang, 1997). In any case, I found quantitative and qualitative content analyses to be complementary, as I explain in my upcoming discussion on data analysis.

Methods

While the previous section focused on the theory behind the research, the focus of this section is the techniques I employed when conducting my research. In this section, I provide an overview of my sample, data collection, and data analysis.

Sample

The sample of newspaper documents for this study came from four Atlantic Canada daily newspapers: (1) *The Chronicle-Herald* (provincial edition) and its Sunday edition, *The Sunday Herald* in Halifax, Nova Scotia; (2) *The Guardian* in Charlottetown, Prince Edward Island; (3) *The New Brunswick Telegraph Journal* in Saint John, New Brunswick; and (4) *The Telegram* in St. John’s, Newfoundland and Labrador. These newspapers were selected because they had the greatest circulation (and readership) within their respective provinces.

The National Audience Database — better known as NADbank — collects readership statistics on the Canadian newspaper market. NADbank (2006) provides a helpful distinction between the terms circulation and readership:

Circulation is the number of newspapers that are printed and distributed each day. Readership reflects the actual number of people who read those newspapers. For example, the newspaper delivered to your home or office is counted as part of that newspaper's circulation. (§ 1)

I confirmed my selection of newspapers by checking the most recent circulation and readership statistics with a marketing staff person from each of the four dailies (T. King, J. Taylor, R. Lund, & K. Connolly, personal communication, March 1, 2005). The most recent circulation and readership statistics for each of the four dailies are provided in Table 1.

Table 1

Circulation, readership, and other recent statistics of four Atlantic Canada daily newspapers: The Chronicle-Herald (provincial edition) and its Sunday edition, The Sunday Herald; The Guardian; The New Brunswick Telegraph Journal; and The Telegram

Newspaper	Overview
<i>The Chronicle-Herald</i> <i>The Sunday Herald</i>	Home: Halifax, Nova Scotia
	Type: Provincial Daily (C.H. runs six days/wk, Mon-Sat, and S.H. runs once/wk, Sun)
	Circulation: ^a Avg. Mon-Fri (107,735); Sat (113,719); Sun (80,147)
	Readership ^b (2005): 190,700 wkly (63 percent reach)
	Ownership: Halifax Herald Ltd.
	Provincial population: ^d 934,400
<i>The Guardian</i>	Home: Charlottetown, Prince Edward Island
	Type: Regional (Sub-provincial) Daily (six days/wk, Mon-Sat)
	Circulation: ^a Mon-Fri (20,237)
	Readership ^b (2003): 44,300 wkly (92 percent reach)
	Ownership: Transcontinental Inc.
	Provincial population: ^d 138,500
<i>The New Brunswick Telegraph Journal</i>	Home: Saint John, New Brunswick
	Type: Provincial Daily (six days/wk, Mon-Sat)
	Circulation: ^a Avg. Mon-Fri (37,322); Sat (40,614)
	Readership ^b (2005): 73,100 wkly (73 percent)
	Ownership: Brunswick News Inc.
	Provincial population: ^d 749,200
<i>The Telegram</i>	Home: St. John's, Newfoundland and Labrador
	Type: Regional (Sub-provincial) Daily
	Circulation: ^c Mon-Fri (31,541); Sat (55,031); Sun (30,186)
	Readership ^b (2004): 114,200 wkly (83 percent reach)
	Ownership: Transcontinental Inc.
	Provincial population: ^d 509,700

Note. From "The ultimate online guide to Canadian newspapers," by Canadian Newspaper Association, 2005, retrieved May 20, 2006 from <http://www.cna-acj.ca/client/cna/ult.nsf/web/CnaSearch?OpenDocument&nLoc=5>

^aFrom "eCirc," by Audit Bureau of Circulations, 2006, retrieved May 20, 2006, from <http://abcas3.accessabc.com/ecirc/index.html>

^bFrom "Weekly readership by resident market — 2005 study (Adults 18+)," by Newspaper Audience Databank Inc., 2006, retrieved May 20, 2006, from <http://www.nadbank.com/English/index.html>

^cFrom "Canadian circulation data," by Canadian Newspaper Association, 2005, retrieved May 20, 2006, from <http://www.cna-acj.ca/client/cna/ult.nsf/ccsearch?OpenForm>

^dFrom "Population by year, by province and territory" by Statistics Canada, 2006, retrieved Mar 3, 2006, from <http://www40.statcan.ca/101/cst01/demo02a.htm>

The sample of newspaper documents for this study includes a collection of news articles, editorials, columns, and letters to the editor (see Table 2 for definitions). While some researchers choose to include only news articles in their analysis, others cite good reasons for also including opinion pieces. Lima and Siegal (1999) excluded editorials and other opinion pieces because they were interested in “how the [news] media were framing the tobacco settlement debate in their primary news coverage, not in how editorial boards and commentators were framing the debate” (p. 249). Contrarily (and as per my own research) Anhang et al. (2003) included opinion pieces “to reflect the overall content of the newspapers” (p. 309).

Table 2

Definitions of types of newspaper documents

Type of Newspaper Document	Definition
Column	An article in which a writer or columnist gives an opinion on a topic
Editorial	An article expressing a newspaper or magazine owner’s or editor’s position on an issue
News article	Includes: <ul style="list-style-type: none"> • “Hard news” — factual accounts of important events, usually appearing first in a newspaper; and • “Soft” or “feature” news — stories that are interesting but less important than hard news, focusing on people as well as facts and information and including interviews, reviews, articles, and editorials
Letter to the editor	A letter sent to the editors of a publication or periodical about materials that have appeared in the publication or issues of concern to the readership

Note. From “Journalism studies 20: A curriculum guide for the secondary level,” by Saskatchewan Education, 1998, Regina, SK: Saskatchewan Education.

To retrieve a sample for a news media representation study, researchers typically depend on generating search terms to search in newspaper databases for their study subject. My sample of newspaper documents was drawn from the four specified dailies over the time period of January 1, 2003 to December 31, 2005. The inclusion criteria were the headline and/or lead (the

first one or two paragraphs, depending on the newspaper database, as I will explain later) of each newspaper document must contain at least one of the following search terms: waitlist, waitlists, wait list (same as wait-list), wait lists (wait-lists), wait time (wait-time), wait times (wait-times), waiting time, waiting times, waiting list, and waiting lists. The article not being about waiting times for and/or waiting lists related to medical services was the only exclusion criteria. In the final sample, there were 407 articles: 145 from *The Chronicle-Herald* and *The Sunday Herald*, 79 from *The Guardian*, 84 from *The New Brunswick Telegraph Journal*, and 99 from *The Telegram* (see Appendix G for the number of documents retrieved by search term in the initial search).

Table 3

Total number of newspaper documents retrieved using specified search terms, within the time period January 1, 2003 to December 31, 2005, searching with the headline and lead, for four Atlantic Canada daily newspapers: The Chronicle-Herald and its Sunday edition, The Sunday Herald; The Guardian; The New Brunswick Telegraph Journal; and The Telegram

Newspaper	Original search results (number of newspaper documents)	Rejected stories ^a	Final sample (number of newspaper documents)
<i>The Chronicle-Herald</i> <i>The Sunday Herald</i>	270	111	159
<i>The Guardian</i>	122	39	83
<i>The New Brunswick Telegraph Journal</i>	126	41	85
<i>The Telegram</i>	145	40	105
TOTAL	663	231	432

^aIncludes stories that were not about waiting times and/or waiting lists for medical services or stories that are duplicates (that is, stories that were retrieved more than once, using different search terms).

Justification of my sample

Provincial (or regional) newspapers versus national newspapers

I drew my sample from provincial and regional newspapers versus national newspapers for three primary reasons:

- **Cost:** Since I did not have access through my university to a newspaper database that carried national newspaper archives, I would have had to shoulder the costs of subscribing to a database and retrieving these data. I found the database subscriptions as well as the cost of retrieving national newspaper documents were unavoidably costly and beyond my financial means.
- **Specificity:** My literature review revealed that while there are a number of nationally focused Canadian newspaper analyses, few studies incorporate newspapers from Atlantic Canada. In fact, I have yet to see (in the published literature) an example which incorporates newspapers from New Brunswick, Newfoundland and Labrador, or P.E.I. Meanwhile, *The Chronicle-Herald* is reported in the published literature (see Hayes et al., in press). By focusing on newspapers within the Atlantic region, I am adding to the current body of knowledge on news media portrayal in Canada.
- **Gap in the literature:** In Canada, the federal and provincial/territorial governments have designated and defined roles within the health care system. It is the Constitution Act, 1867 (renamed from the British North America Act) that designates responsibilities of the different orders of government in Canada (Government of Canada, 1867). According to the constitution, the provincial and territorial governments have jurisdiction over health services delivery, including physician services and hospitals (Government of Canada, 1867). Given that the constitution assigns jurisdiction over health services delivery to

Canadian provinces and territories, it seems fitting to conduct an analysis of newspapers about waiting times for medical services from a provincial perspective.

Time period

In the research I consulted, most drew their sample from a time period corresponding to a particular event (Cassels et al., 2003a, 2003b; Wallis & Nerlich, 2005; Haas et al., 2004; Lawton et al., 2003). For example, in their analysis of Canadian newspaper coverage of new prescription drugs launched between 1996 and 2000, Cassels et al. (2003a, 2003b) retrieved articles published in 2000. I chose to draw my sample from the time period of January 1, 2003 to December 31, 2005, as during this time federal, provincial, and territorial governments were heavily engaged in initiatives aimed at improving waiting times and waiting list management. This period is book-ended by two key public policy events: the 2003 First Ministers' Accord on Health Care Renewal, in which First Ministers committed to reducing waiting times; and the reaching of the first of these commitments with the December 2005 establishment of common waiting time benchmarks.

Limiting the search to the headline and lead

Search results of the full text yielded unmanageably large sample sizes. Through a preliminary search, I determined it would be wise to limit my search for newspaper documents to those containing the specified search terms in the headline and/or lead. According to the newspaper archival database, Virtual News Library (2005), a search of the full text (from the headline to the final line) is "ideal for finding everything written on a given topic," while a search of the lead is "ideal for finding documents that discuss a given topic." Throughout my preliminary search, I found that documents with one of the search terms within the document (rather than in the lead or headline) made only a passing reference to health care waiting times.

Data Collection

Data collection for the textual analysis of newspaper documents began with a consideration of key words relating to waiting times for medical services. To retrieve my sample, I searched for key terms in the heading and lead of newspaper documents over a specified time period. Rather than using a finite “search string” of terms, if new search terms arose during data collection, these were also used. This method is congruent with Hayes et al. (in press), as it allowed new search terms to arise as the study progressed, thereby allowing a broad sample.

I conducted my search primarily using Virtual News Library, a newspaper archival database. During data collection, the newspaper company Brunswick News Inc. pulled its newspaper archives from all newspaper databases except FP Infomart. As a result, I had to conduct the remainder of my search for articles (that is, for those stories dated September 2, 2005 to December 31, 2005 in *The New Brunswick Telegraph Journal*) using a second newspaper archival database. Since FP Informart provides access to *The Telegram*, I also used this database to validate the search results I had already acquired using Virtual News Library (see Appendix H for the number of articles retrieved using each database and for *The New Brunswick Telegraph Journal* and *The Telegram*). Wells et al. (2001) conducted a search of two databases — searching the second database as a means of testing the reliability of their primary database. Unfortunately, there were no other databases available to validate my findings for *The Guardian* or *The Chronicle Herald*.

As I retrieved a newspaper document that fit my inclusion criteria, I saved it in the qualitative data software program QSR NVivo (Version 7.0). This program was used to collect data for both the quantitative and qualitative portion of this study (as NVivo allows variables to

be collected as attributes in an attribute table, and for themes and sub-themes to be coded as parent and child nodes, respectively).

Following my methodology, which incorporates qualitative and quantitative content analysis, data collection for this study operated on two levels: (1) as per quantitative content analysis, data collection entailed counting the occurrence of specified variables within the text; and (2) as per qualitative content analysis, data collection (and analysis) occurred simultaneously, with categories and themes emerging from the data. To determine what variables or attributes to count and begin to immerse myself in the data for the qualitative portion of my study, I read through the data twice. It was this process of reading through the data that enabled me to compile a preliminary coding template for the quantitative portion of my study. During data collection, I finalized this coding template (see Table 4). While reading through the newspaper documents I was also able to get a sense of the kinds of topics or themes emerging from the texts. I jotted down a list of preliminary thematic headings to help guide my qualitative content analysis and proceeded with data collection.

Table 4

Preliminary attributes (and their descriptors) to be accounted for per unit (newspaper document)

Attribute (Variable)	Description
Location	Newspaper: <ul style="list-style-type: none"> • <i>The Chronicle-Herald /The Sunday Herald</i> (NS) • <i>The Guardian</i> (PE) • <i>The New Brunswick Telegraph Journal</i> • <i>The Telegram</i> (NL)
	Section: <ul style="list-style-type: none"> • A1 (Front page), A2, A3, A4, A5, A6, A7-A15, B1, B2-B12, or C, D, and F • No page number assigned
Date	Day/month/year
Length	Word count: <ul style="list-style-type: none"> • 150 or less, 151-350, 351-550, 551-750, 751-950, or

	951+
Type	<ul style="list-style-type: none"> • News article • Column • Editorial • Letter to the editor • Other
Illustrations	Y/N
	Subject
Distinct Byline (Author Identification)	<ul style="list-style-type: none"> • Articles without byline • Articles without byline (newspaper cited) • Article without byline (news service cited) • Distinct byline (reporter identified)
Tone	<ul style="list-style-type: none"> • Negative • Positive • Neutral
Quoted Sources	Number: <ul style="list-style-type: none"> • 0, 1, 2, 3, 4, 5, 6, 7
	Descriptor: <ul style="list-style-type: none"> • Federal/provincial/territorial department of health representatives • Physicians/medical professional associations • Other health care providers • Health system decision makers • Academic researchers • Think-tanks and interest groups • Research funding organizations • Disease groups • Patients/patient relatives • Miscellaneous
Kinds of Reported Evidence	<ul style="list-style-type: none"> • Research • NGO reports • Government reports and royal commissions • Anecdotal
Kinds of Waits	<ul style="list-style-type: none"> • Joint replacement (hip and knee) • Diagnostic services (CT and MRI) • Cancer care • Cardiac care • Sight restoration • Other (autism, arthritis, and addiction)

In addition to assessing whether a photo was present, I also assessed the content of the photo based on the photo caption (because the photo itself was not available through the newspaper databases).

To define tone, I referred to work by Collins et al. (2006), in which the investigators studied how the 2002 Canadian health care reform debate was represented in nine daily newspapers. According to Collins et al. (2006):

Article tone was determined by the overall impression of the future of Canada's public healthcare system, as conveyed by the article's author (and not necessarily the actors represented in the article). Articles that presented a positive outlook on the future of the healthcare system were coded as conveying a positive tone, and articles with a negative outlook were coded as conveying a negative tone. Articles that did not convey clearly positive or negative impressions were coded as neutral, which was often the case with articles that reiterated one of the report's recommendations or cited a research study.

Tone coding was based on gestalt of phrases and ideas, and not simply a statement from the article. (p. 94-95)

In my study, tone involved assessing whether the article had an overall positive, negative, or neutral tone about waiting times for medical services. For this subjective category, I assessed whether the article made an overall positive reference to waiting times (that is, waiting times are decreasing or improving), an overall negative reference to waiting times (that is, waiting times are increasing or worsening), or an overall neutral reference to waiting times (that is, waiting times are mentioned, but there is no reference to whether they are decreasing and improving or increasing and worsening, respectively). With that said, neutral did not mean a balance of positive and negative messaging. In those cases where news documents incorporated positive

and negative messaging, I assigned tone based on two factors: first, an assessment of which messages (be they positive or negative) appeared in the lead (headline and/or first two paragraphs); and, if the first assessment failed, second, an assessment of which messages made up most of the article. To ensure the reliability of my coding scheme, I used an intra-rater reliability technique, whereby I coded for tone a second time, while being blind to my initial coding. Where I found disagreement, I consulted the newspaper documents and re-coded.

Issues with Data Collection and the Sample

There were four main issues I encountered with my sample. First, distinguishing which of the daily newspapers had the greatest circulation was challenging for the province of New Brunswick. In New Brunswick, *The Times & Transcript* — a city-focused daily newspaper published in Moncton — has comparable circulation and readership statistics to *The New Brunswick Telegraph Journal*. In fact, the latest figures for these two newspapers (from the Audit Bureau of Circulations and NADbank) suggest *The Times & Transcript* has slightly greater circulation and readership than *The New Brunswick Telegraph Journal*. At the time data collection commenced, I contacted a second marketing staff person to confirm my selection for the newspaper with the greatest circulation and readership. Since both newspapers are owned by the same company, the staff person was able to make an informed decision that *The New Brunswick Telegraph Journal* had the greater circulation in New Brunswick (S. Cail, personal communication, April 19, 2005).

Second, during data collection, I realized some of the stories I had retrieved from *The Chronicle Herald* were labelled as coming from the provincial edition; others specified coming from the metropolitan edition; and still others had no edition specified. Upon calling *The Chronicle Herald* library, a librarian informed me that those stories that were unlabelled came

from the provincial edition, which had greater circulation than the metropolitan edition and were printed first (D. Reid, personal communication, June 13, 2006). I opted to reject the stories that came from the metropolitan version so I could focus on those from the provincial edition. I reviewed these articles with the librarian (over the phone and via e-mail) before discarding them. The librarian also explained that the metropolitan edition stories were sometimes “makeover” stories, that is, the stories were revised versions of already-printed provincial-edition newspaper documents.

Third (and also during data collection), the newspaper company Brunswick News Inc. pulled its newspaper archives from all newspaper databases except FP Infomart. Although I had already acquired most of my stories from the Virtual News Library database, I had to use FP Infomart to collect the remainder of my sample for *The New Brunswick Telegraph Journal*. Both databases are capable of searching for key words in the headline and lead of the newspaper document. However, each database defined “lead” differently: Virtual News Library defined the lead as the first two paragraphs of a document; FP Infomart defined it as the first paragraph of a document. To assess the differences in the search results from each database, I ran the search again for the same time period as when I had used Virtual News Library. Since FP Informart had newspaper archives for *The Telegram*, I also ran a comparison search for this newspaper. As suspected, Virtual News Library yielded a greater number of articles with the search terms (see Appendix H for the number of articles retrieved from each of these searches).

Fourth, although I was able to validate my search findings for *The New Brunswick Telegraph Journal* and *The Telegram* using two newspaper archival databases, I was unable to do so for the other two newspapers in my sample. A lack of database availability and budget

limitations prevented validation of my search findings for *The Guardian* and *The Chronicle Herald*.

Data Analysis

I used both a qualitative and quantitative content analysis approach to guide my textual analysis of newspaper documents. On the one hand, I allowed categories to emerge from the newspaper documents and for analysis to involve reflexivity (Hardy et al., 2004). On the other hand, I used traditional quantitative content analysis such that I counted the occurrence of particular variables in the newspaper documents.

Quantitative content analysis

In a quantitative-based content analysis, it is assumed that meaning is consistent, thereby allowing for occurrences of words and other larger units of text to be counted (Hardy et al., 2004, p. 20). In fact, when creating categories for quantitative content analyses, these should be defined so specifically that several coders could apply them and reach the same findings (Hardy et al., 2004). For example, in their content analysis of newspaper documents relating to diet, activity, and tobacco in local newspapers from four mid-sized Missouri communities, Caburnay et al. (2003) developed a coding template, which included story prominence, topical focus, story origin, story type, and research content.

It is in the analysis stage where categories may be counted and used to create frequency tables, showing the number of times certain words or phrases have been mentioned in a given text. Based on a set of developed criteria for each of their coding categories, Caburnay et al. (2003) compiled a database, which they later used to conduct basic descriptive and inferential

statistical analyses. And in Lima and Siegal (1999) and Durrant et al. (2003), tables display the number and percentage of newspaper articles by theme, article type, and prominence.

The variable data that I collected using NVivo were transported into a database, where I analysed the findings using Microsoft Excel. I then conducted frequencies and cross-tabulations to describe the sample. Frequency refers to “the number of times that a particular score appears in a set of data” (Argyrous, 2000, p. 41), while a cross-tabulation “displays the joint frequency distribution for two variables” (Argyrous, 2000, p. 501). In particular, I compiled frequencies for all of my attributes. I then conducted cross-tabulations to yield further results.

One such cross-tabulation yielded the attribute story prominence, which other researchers have calculated in their media representation studies (see Caburnay et al., 2003; Durrant et al., 2003; Lima & Siegal, 1999). In this case, I ran a cross-tabulation of four variables to get an indication of the number of prominent news documents. In particular, the following four variables are thought to indicate story prominence:

- section (with section A1 as the most prominent and section A being more prominent than other sections);
- word count (with longer word counts as the most prominent);
- type (with news articles as more prominent than columns and editorials, and these being more prominent than letters to the editor and other); and
- illustration (with those articles with an illustrations as more prominent than those without).

With this in mind, a news article that is in section A1, has a high word count, and has an illustration would be considered to have the greatest story prominence.

Qualitative content analysis

Qualitative data analysis can be both exciting and intimidating (Rubin & Rubin, 1995). In this final stage of listening to hear meaning in what is said and watching to see meaning in what is observed (Antaki, 1988), the researcher can easily become overwhelmed with the task of discovering themes embedded in the data (Bereska, 2003; Holliday, 2002; Rubin & Rubin, 1995). In this section, I outline my data analysis techniques and sources of inspiration.

An overview of conducting qualitative analysis

In qualitative analysis, researchers endeavour “to locate patterns or themes that are embedded in the data” (Rothe, 2000, p. 140). From a basic perspective, qualitative analysis involves “find[ing] underlying ideas, group[ing] similar categories and themes together, and relat[ing] different themes to one another” (Rothe, 2000, p. 140). The actual process of conducting qualitative analysis is fraught with complexities, however. When qualitative researchers work inductively, they are looking for “emergent patterns in the data” (Patton, 2002, p. 468). These patterns, Patton (2002) explains, “can be represented as dimensions, categories, classification schemes [and/or] themes” (p. 468). Before I could sensibly devise a plan for my analysis, I had to develop a thorough grasp of these terms. I relied on Rothe’s (2000) definitions, which state “Categories refer to text that speaks to a concept or idea [and] [t]hemes include different categories” (Rothe, 2000, p. 143). These definitions enabled me to gain an appreciation for what is expected from my analysis: shaping themes based on emergent patterns of like (and unlike) categories.

Self-reflexivity and journaling

Throughout data analysis, I asked myself such questions as: “What do I know? How do I know what I know? [And,] [w]hat shapes and has shaped my perspective?” (Patton, 2002, p. 495).

Developing a coding scheme, marking texts, and building categories

The real “heart and soul” of textual analysis is coding (Ryan & Bernard, 2000, p. 780). This stage “forces the researcher to make judgments about the meanings of contiguous blocks of text” (p. 780). These blocks of text are the researcher’s units of analysis (Ryan & Bernard, 2000). The units themselves may be anything from single words to sentences to paragraphs to entire transcripts to anything in between (Ryan & Bernard, 2000). For my analysis, I considered the unit of analysis to be chunks of text, as I saw these as reflecting ideas and concepts.

After establishing my unit of analysis, I started to think about the steps I would take to code and categorize my data. To guide my analysis, I relied on two authors’ step-by-step coding strategies: (1) Holliday’s (2002) six-step strategy on arriving at themes; and (2) Rothe’s (2000) 13-step strategy for performing surface analysis (see Appendix I for these strategies).

To develop my categories, I read through my newspaper documents marking chunks of text with code phrases (the category names). I analysed all of the text — from the headline to the final word in the document — when allowing categories and themes to emerge. As I read through more texts, I found myself entering into a process of reading and re-reading, constantly comparing new with already-categorized information. This comparison and contrasting process became one of meticulous category-refining.

Refining my approach to data analysis as my “findings” emerge

By this stage, I had repeatedly read, reviewed, and compared the newspaper documents for category and theme development to the point of saturation. It was in this stage, in particular,

where I found myself struggling to find the “right” phrases to communicate my findings. I relied on Patton’s (2002) advice that “there is no absolutely ‘right’ way of stating what emerges from the analysis[;] There are only more and less useful ways of expressing what the data reveal” (Patton, 2002, p. 476).

Making Informed Assertions Based on the Literature and My Findings

In chapter one, I presented a timeline of significant Canadian waiting time policy and research developments that have taken place over the same time period from which I drew my sample. Similarly, in my literature review, I presented an overview of health literacy. When discussing my findings, I referred to this literature as a way of making informed assertions about how news coverage of waiting times can influence Canadian health policy regarding waiting times for medical services and the public’s knowledge of health services (respectively).

Grilli et al. (2002) acknowledge that the impact of health news is difficult to measure. In my study, I aimed to realize the impact of my sample on neither public policy nor health literacy. Instead, I claim only to discuss possible implications of this news coverage. Discussion of these implications has been reserved for a distinct section within my discussion.

Making Sense of the Datasets

Data collected using differing methods is said to “defy direct comparison” (Barbour, 2001, p. 1117). Instead, one must consider differing methods as complementary in nature. The methods I used were complementary such that the qualitative portion of the study provided depth and breadth, while the quantitative portion provided broad demographic patterns and trends. These strengths are apparent in other studies employing quantitative and qualitative approaches.

For example, in a study of medical and health stories on the *Sydney Morning Herald's* front page, Lupton (1995) conducted a qualitative discourse analysis (in addition to a quantitative textual analysis) as a means of “[going] beyond the text to discern the subtextual discourses evident in the news texts in the context of the wider socioeconomic and political settings in which they were expressed” (p. 502). Similarly, in their study on the portrayal of genetic risk of breast cancer in ethnic and non-ethnic Canadian newspapers, Donelle et al. (2004) conducted basic descriptive statistics to complement their qualitative analysis. In the end, employing the two techniques yielded richness in findings and strength in design.

Strengths of My Research Design

One of the key strengths of my research design is that its qualitative nature is well-suited to my broad research questions, where I seek to describe the general characteristics and themes that arise from Atlantic Canada daily newspaper coverage of waiting times for medical services. Creswell (1994) says “one of the chief reasons for conducting a qualitative study is that the study is exploratory; not much has been written about the topic or population being studied, and the researcher seeks to listen to informants and to build a picture based on their ideas” (p. 21).

An additional strength of my research design is the use of multiple methods or triangulation. Triangulation is thought to increase the reliability and validity of qualitative research (Mays & Pope, 1995; Morse, 1994; Silverman, 1998). Furthermore, using multiple methods allowed me to draw on the strength of each approach, thereby strengthening the totality of my findings.

Chapter Summary

In this chapter, I provided transparent details of the theoretical underpinnings of my research as well as the methods used to conduct my research. In chapter four, I share the culmination of this work, which includes basic frequencies and cross-tabulations as well as thematic analysis findings.

CHAPTER FOUR: RESULTS

The results section provides an overview of one's observations. In this section, I present my observations in the form of statements, tables, figures, and segments of text from the articles in my sample. Overall, I have aimed to present sufficient details so that in my discussion I may draw inferences and explanations. This chapter is arranged according to the objectives of my study, which aims to explore and describe a sample of Atlantic Canada daily newspaper coverage of waiting times for medical services. I begin with presenting the sample characteristics and finish with the results of my thematic analysis.

Sample Characteristics

As per my objectives, I begin by describing the general characteristics that arise from Atlantic Canada daily newspaper coverage and, where appropriate, compare and contrast these characteristics across the four newspapers in my sample. Among the sample characteristics are location, length, and type of articles, illustrations, bylines (author identification), tone, quoted sources, kinds of reported evidence, and major and minor news topics. In this section, I also show how some of these characteristics can inform us about story prominence. Where appropriate, I also provide segments from the text to further illustrate certain characteristics.

Location, Length, and Type of Article

During the 36-month study period (January 1, 2003 to December 31, 2005), 663 newspaper documents (including news articles, columns, editorials, and letters to the editor) making reference to waiting times for medical services in the headline and lead were published in four Atlantic Canada daily newspapers: *The Chronicle-Herald* (provincial edition) and its Sunday edition, *The Sunday Herald*, *The Guardian*, *The New Brunswick Telegraph Journal*, and

The Telegram. Details about the final sample's location (newspaper, date, and section), length (word count), and type of articles (news article, column, editorial, or letter to the editor) are presented in this section.

Newspaper

Reading through the sample revealed that some of the articles were not about waiting times for medical services. In particular, some of the articles mentioned waiting times for things other than medical services. In other cases, waiting times were mentioned in only one sentence, with the article focusing on another topic entirely. These extraneous items were weeded out, leaving the final sample with 407 articles as follows: *The Chronicle-Herald* and *The Sunday Herald* (145/407, 35.6%), *The Telegram* (99/407, 24.3%), *The New Brunswick Telegraph Journal* (84/407, 20.6%), and *The Guardian* (79/407, 19.4%).

Calendar Year

According to year, 45% (183/407) of the articles were published in 2005; while 38.3% (156/407) were published in 2004, and 16.7% (68/407) were published in 2003.

Section

Half (204/407, 50.1%) of the articles in the sample were located in sections A1 to A6, with 16% of the articles (65/407) in these sections published on the front page (section A1). Overall, the large majority (318/407, 78.1%) of the articles were published in section A (including A1-A15). Overall, *The Chronicle Herald* had the highest absolute number, but *The Telegram* had the highest proportion of front-page articles. In Table 5, some of the newspaper sections are grouped, while others are not — since the front sections are most important (from a prominence perspective), going any further into depth seemed unnecessary.

Table 5

Number and percentage of articles relating to waiting times per newspaper section, from four Atlantic Canada daily newspapers (01/01/2003 to 12/31/2005)

Section	Count	Proportion of total articles (%)
A1	65	16
A2	10	2.5
A3	36	8.8
A4	36	8.8
A5	27	6.6
A6	30	7.4
A7-A15	114	28
B1	16	3.9
B2-B12	30	7.4
C, D, and F	18	4.4
No page number assigned	25	6.1
Total	407	100

Table 6

Number and percentage of articles pertaining to waiting times that were published on the front page of four Atlantic Canada daily newspapers (01/01/2003 to 12/31/2005)

Newspaper	Total number of articles	# of articles on front page (% of total number of articles)
<i>The Chronicle-Herald/The Sunday Herald</i>	145	23 (15.9)
<i>The Guardian</i>	79	12 (15.2)
<i>The New Brunswick Telegraph</i>	84	12 (14.3)
<i>The Telegram</i>	99	18 (18.2)
Total	407	65 (68.6)

Word Count

The articles varied in length from as little as 50 words to as many as 1,500, with the majority (59.9%) having between 351 and 750 words. As observed in Table 7, most articles published in each of *The Chronicle-Herald* and *The Sunday Herald*, *The New Brunswick Telegraph Journal*, and *The Telegram* ranged between 351 to 750 words. *The Guardian*, however, had predominantly shorter articles (151 to 350 words).

Table 7

Number and percentage of articles by word count and newspaper, from four Atlantic Canada daily newspapers (01/01/2003 to 12/31/2005)

Word Count	Newspaper articles # (%)			
	<i>The Chronicle-Herald/The Sunday Herald</i>	<i>The Guardian</i>	<i>The New Brunswick Telegraph Journal</i>	<i>The Telegram</i>
150 or less	9 (6.2)	13 (16.5)	5 (6)	6 (6.1)
151-350	29 (20)	25 (31.6)	14 (16.7)	16 (16.2)
351-550	55 (37.9)	23 (29.1)	27 (32.1)	38 (38.4)
551-750	34 (23.4)	13 (16.5)	30 (35.7)	24 (24.2)
751-950	14 (9.7)	4 (5.1)	6 (7.1)	10 (10.1)
951+	4 (2.8)	1 (1.3)	2 (2.4)	5 (5.1)
Total	145 (100)	79 (100)	84 (100)	99 (100)

Type

Approximately 80% (323/407) of the articles in the sample were news articles, followed by columns (36/407, 8.8%), editorials (25/407, 6.1%), and letters to the editor (18/407, 4.4%). Several articles (5/407, 1.2%) fell outside of these categories and are labelled herein as “other.” The articles in this category primarily came from *The New Brunswick Telegraph Journal*. For example, in the newspaper’s “Readers’ Forum,” the feature, “Street Sense” publishes a series of responses to questions posed of the general public. In response to the question “What is at the top of your list for spending initiatives by the provincial government,” for example, respondent Linda Friars of Saint John, replied “Health care — there’s too much waiting time for surgeries” (Saturday, December 11, 2004, p. D7). Another example of a news item that was labelled as “other” comes from the same newspaper — particularly from a section called “The Voice of New Brunswick.” Here is an example of the text from this section:

There may be legitimate reasons why waiting lists for surgeries are growing, but there are no excuses for the committee struck to address this issue to have done practically nothing on this file in the past year. If they can’t fit meetings into their schedules, then step aside

and let others run with the ball. It's as simple as that. Your chance to voice an opinion on any matter, great or small. Call . . . It's not necessary to leave your name. All calls will be edited for space, slander and clarity. (Tuesday, July 12, 2005, p. A7)

As observed in Table 8, *The Chronicle-Herald* had the greatest showing of columns and editorials, while *The New Brunswick Telegraph Journal* had the greatest showing of letters to the editor (Table 8).

Table 8

Number and percentage of articles by type and newspaper, from four Atlantic Canada daily newspapers (01/01/2003 to 12/31/2005)

Type	Newspaper articles # (%)			
	<i>The Chronicle-Herald/The Sunday Herald</i>	<i>The Guardian</i>	<i>The New Brunswick Telegraph Journal</i>	<i>The Telegram</i>
News articles	109 (75.2)	63 (79.7)	68 (81)	83 (83.8)
Columns	15 (10.3)	7 (8.9)	5 (6)	9 (9.1)
Editorials	17 (11.7)	5 (6.3)	1 (1.2)	2 (2)
Letters to the editor	4 (2.8)	4 (5.1)	6 (7.1)	4 (4)
Other	0 (0)	0 (0)	4 (4.8)	1 (1)
Total	145 (100)	79 (100)	84 (100)	99 (100)

Illustrations

Approximately 22.1% of the articles featured a photo (90/407), with most of these published in *The Chronicle-Herald* and *The Sunday Herald*, followed by *The Guardian* (Table 9). Of all persons portrayed in these photos, FPT non-health department representatives were featured the most frequently (42/115, 36.5%), followed by FPT department of health representatives (21/115, 18.3%), patients (or their relatives) (16/115, 13.9%) and non-physician health care providers (14/115, 12.2%) (particularly nurses, but also technologists, with few others). Physicians (including those representing professional associations) were the fourth most frequently photographed group (11/115, 9.6%), with health system decision makers (such as

hospital chief executive officers, vice-presidents, or directors) being photographed the least (6/115, 5.2%), just before the miscellaneous category (5/115, 4.3%). Note that the total number of illustrations showing persons (n = 115) is greater than the number of articles with illustrations (n = 90), as some illustrations showed more than one person. Examples of photo captions for each group follow, respectively:

Health Minister Pierre Pettigrew responds to questions about revamping the federal health care system (The Canadian Press, 2004a).

Forest Fall of Charlottetown says he spent more than three hours waiting and bleeding in the emergency room of the Queen Elizabeth Hospital in Charlottetown before being referred to Summerside, 71 kilometres away. Fall said waiting times must be reduced at P.E.I.'s main referral hospital (Thibodeau, 2004a).

Emergency room nurse Amy King checks equipment at Dartmouth General Hospital on Thursday (Parsons, 2004).

Albert Schumacher of the Canadian Medical Association: Canada lags "far behind" (The Canadian Press, 2005a).

Patrick Lee, executive director of the Queen Elizabeth Hospital, left, speaks with Lisa Matheson, and Libba Mobbs, nurses in the pediatrics unit at the QEH (Taweel, 2005).

Prime Minister Paul Martin campaigned on the promise that he would address health-care issues (The Chronicle Herald, 2004).

Table 9 shows the number of illustrations published by each newspaper.

Table 9

Number and percentage of articles with illustrations by newspaper, from four Atlantic Canada daily newspapers (01/01/2003 to 12/31/2005)

Newspaper	Total number of articles	# (%) of articles with an illustration
<i>The Chronicle-Herald/The Sunday Herald</i>	145	46 (34.1)
<i>The Guardian</i>	79	21 (26.6)
<i>The New Brunswick Telegraph Journal</i>	84	13 (15.5)
<i>The Telegram</i>	99	10 (10.1)
Total	407	90

Story Prominence

Four attributes are thought to give some indication as to how prominent a given article is (Caburnay et al., 2003; Durrant et al., 2003; Lima & Siegal, 1999). These attributes are (1) section (with section A1, as the most prominent and section A being more prominent than other sections); (2) word count (with greater word counts as more prominent); (3) type (with news articles as more prominent than columns and editorials, and these as more prominent than letters to the editor); and (4) illustration (with articles having an illustration as more prominent than those without). According to these criteria, the most prominent article is a news article that is in section A1, has among the highest word counts, and an illustration. A comparison of cross-tabulations for each newspaper finds that *The Chronicle-Herald* and *The Sunday Herald* have the highest number of prominent articles.

Table 10.1

Number of news articles in The Chronicle-Herald and The Sunday Herald by section, word count, and illustration (01/01/2003 to 12/31/2005)

Section	A1		A2		A3		A4		A5		A6		B1	
	Yes	No												
Illustration														
Word count														
150 or less	-	2	-	-	-	-	-	2	-	-	-	2	-	-
151-350	-	1	-	-	1	3	-	1	-	3	-	1	-	-
351-550	2	3	-	-	2	5	2	3	1	1	1	1	5	2
551-750	3	3	-	-	2	2	-	1	-	-	1	-	1	-
751-950	3	4	-	-	1	-	-	-	-	-	-	-	2	-
951+	2	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 10.2

Number of news articles in The Guardian by section, word count, and illustration (01/01/2003 to 12/31/2005)

Section	A1		A2		A3		A4		A5		A6		B1	
	Yes	No												
Illustration														
Word count														
150 or less	-	3	-	-	-	2	-	2	-	-	-	-	-	-
151-350	1	1	-	-	-	1	1	-	1	2	-	-	-	-
351-550	3	1	-	-	-	2	2	1	2	1	-	-	-	-
551-750	1	2	-	-	-	1	1	-	1	-	-	-	-	-
751-950	-	-	-	-	-	-	-	-	-	-	-	-	-	-
951+	-	-	-	-	1	-	-	-	-	-	-	-	-	-

Table 10.3

Number of news articles in The New Brunswick Telegraph Journal by section, word count, and illustration (01/01/2003 to 12/31/2005)

Section	A1		A2		A3		A4		A5		A6		B1	
	Yes	No												
Illustration														
Word count														
150 or less	-	-	-	1	-	-	-	-	-	-	-	-	-	-
151-350	-	-	-	1	-	-	-	-	-	-	-	-	-	-
351-550	1	-	-	2	-	2	1	-	-	-	-	-	-	1
551-750	-	-	-	2	-	-	1	3	-	-	-	-	-	-
751-950	-	-	-	1	-	-	-	-	-	-	-	-	-	-
951+	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 10.4

Number of news articles in The Telegram by section, word count, and illustration (01/01/2003 to 12/31/2005)

Section	A1		A2		A3		A4		A5		A6		B1	
	Yes	No												
Illustration														
Word count														
150 or less	-	2	-	-	-	-	-	2	-	1	-	-	-	-
151-350	-	1	-	-	-	1	-	3	-	2	-	1	-	-
351-550	-	5	-	-	-	1	1	-	1	4	-	2	-	1
551-750	-	3	-	-	-	6	1	5	1	3	-	-	-	-
751-950	1	3	-	-	-	1	1	1	-	-	-	-	1	-
951+	2	1	-	-	-	-	-	-	-	-	-	-	-	-

Distinct Bylines (Author Identification)

Per newspaper, *The Chronicle-Herald* had the greatest number (50/109, 45.9%) of news articles written by staff reporters, but *The New Brunswick Telegraph Journal* had the greatest proportion (40/68, 58.8%). Meanwhile, *The Telegram* had 41% (34/83) of its news articles written by a staff reporter, while *The Guardian* had 19% (12/63).

The New Brunswick Telegraph Journal had the greatest number of staff reporters (17/39, 43.6%), followed by *The Chronicle Herald* (14/52, 26.9%), *The Telegram* (7/39, 17.9%), and *The Guardian* (5/11, 45.5%). With that said, only *The Chronicle-Herald* and *The Telegram* identified health reporters (with two and one reporters identified, respectively). These reporters were accountable for 14.7% (16/109) and 25.3% (21/83) of the total news articles per newspaper (respectively). This is not to say that other newspapers did not have such reporters; however, they were not identified in the byline.

Meanwhile, 33.1% (107/323) of the total news articles were written by reporters who wrote between six and 27 articles on waiting times for medical services. Nearly the same amount (110/323, 34%) was without a byline. And 23.8% (77/323) of news articles were written by a

reporter who wrote only one or two articles. For comparison persons, news articles, columns, and editorials¹ have been separated in Tables 11 through 13, respectively.

Table 11

Number and percentage of news articles by byline, from four Atlantic Canada daily newspapers (01/01/2003 to 12/31/2005)

Byline	Number of news articles per byline	Total news articles	Percentage of total news articles (%)	Percentage of total articles (%) (n = 407)
Article without byline	29	29	9	7.1
Article without byline (newspaper cited)	12	12	3.7	2.9
Article without byline (news service cited)	69	69	21.4	17
Dennis Bueckert	27	27	8.4	6.6
Deana Stokes Sullivan	21	21	6.5	5.2
David Jackson	12	12	3.7	2.9
Sheryl Ubelacker	10	10	3.1	2.5
Dan Arseneault; Amy Smith	9	18	5.6	4.4
John Gillis	7	7	2.2	1.7
Nina Chiarelli; Kathy Kaufield	6	12	3.7	2.9
Derwin Gowan; John Ward; Wayne Thibodeau; Jeffery Simpson; Richard Roik	4	20	6.2	4.9
Helen Branswell; Michelle MacAfee; Sarah McGinnis	3	9	2.8	2.2
Alan White; Alexander Panetta; Beverly Ware; Elianna Lev; Gillian Livingston; Helen Moka; James Risdon, Mark Kennedy; Ron Ryder; Sandra Cordon; Steve Macleod; Tera Camus; Tracy Carr; Will Hillard	2	32	9.9	7.9
All other writers	1	45	13.9	11.1
Total	78 individual writers	323	100	79.4

¹ Editorials typically do not have a byline, as it may be assumed these documents tend to express the owner's or editor's position on an issue.

Table 12

*Number and percentage of columns by byline, from four Atlantic Canada daily newspapers
(01/01/2003 to 12/31/2005)*

Byline	Number of columns per writer	Total	Percentage of total columns (%) (n = 36)	Percentage of total articles (%) (n = 407)
Charles S. Shaver; James Travers; Marilla Stephenson	3	9	25	2.2
Deborah Tamlyn; Peter Duffy	2	4	11.1	1
All other writers	1	23	63.9	5.7
Total	28 individual writers	36	100	8.8

Table 13

*Number and percentage of editorials by byline, from four Atlantic Canada daily newspapers
(01/01/2003 to 12/31/2005)*

Byline	Number of editorials per writer	Total	Percentage of total editorials (%) (n = 25)	Percentage of total articles (%) (n = 407)
Article without byline	19	19	76	4.7
Article without byline (newspaper)	2	2	8	0.5
Article without byline (news service)	1	1	4	0.2
All other writers	1	3	12	0.7

Tone

For this subjective category, I assessed whether the article made an overall positive reference to waiting times, an overall negative reference to waiting times, or an overall neutral reference to waiting times. To validate my findings, I used an intra-rater reliability technique. There were only 29/407 (7.1%) instances where there was disagreement between my initial and second coding. To demonstrate tone, excerpts from news documents coded with positive, negative, and neutral tones follow, respectively:

Health Minister Elvy Robichaud injected almost \$2 million into medical imaging equipment for hospitals in Bathurst and Campbellton Monday . . . health authority chairman William Teed did confirm the money would be used for new medical equipment and should cut waiting lists. “The health minister is coming to make an announcement for capital equipment (and) anything in the way of equipment is part of the solution to reduce waiting lists” (Risdon, 2004).

Patients in Newfoundland and Labrador have to wait longer than anyone else in the country for medical specialist appointments, according to the Fraser Institute’s 13th annual survey of hospital waiting times across Canada (Stokes Sullivan, 2003a).

An alliance of physician groups has come up with a timetable prescribing how long patients should have to wait for diagnostic tests and treatment in five key areas of health care. . . The alliance’s interim report, released Sunday, says patients needing emergency diagnostic imaging and treatment should not have to wait more than 24 hours, whether it’s for an MRI scan or radiation therapy for cancer. . . The alliance’s complete report, due in August, will contain final benchmark times (The Canadian Press, 2005b).

Approximately 46% (187/407) of the articles conveyed a negative tone, while 16.2% (66/407) conveyed a positive tone and 38% (154/407) conveyed a neutral tone. Table 14 considers tone of coverage against other article characteristics.

Table 14

Tone of coverage by article type and length, from four Atlantic Canada daily newspapers

(01/01/2003 to 12/31/2005)

Variable	Sub-variable	Count	Positive tone count (%)	Negative tone count (%)	Neutral tone count (%)
Newspaper	<i>The Chronicle-Herald/The Sunday Herald</i>	145	29 (20)	70 (48.3)	46 (31.7)
	<i>The Guardian</i>	79	11(13.9)	32 (40.5)	36 (45.6)
	<i>The New Brunswick Telegraph Journal</i>	84	16 (19)	40 (47.6)	28 (33.3)
	<i>The Telegram</i>	99	10 (10.1)	45 (45.5)	44 (44.4)
Type	News article	323	58 (18)	145 (44.9)	120 (37.2)
	Column	36	3 (8.3)	16 (44.4)	17 (47.2)
	Editorial	25	2 (8)	14 (56)	9 (36)
	Letter to the editor	18	3 (16.7)	10 (55.6)	5 (27.8)
	Other	5	0 (0)	2 (40)	3 (60)
Length	150 or less	33	9 (27.3)	13 (39.4)	11 (33.3)
	151-350	84	18 (21.4)	42 (50)	24 (28.6)
	351-550	143	18 (12.6)	64 (44.8)	61 (42.7)
	551-750	101	16 (15.8)	47 (46.5)	38 (37.6)
	751-950	34	5 (14.7)	17 (50)	12 (35.3)
	951+	12	0 (0)	4 (33.3)	8 (66.7)

Quoted Sources

Approximately 58% (186/323) of the news articles in the sample contained one or two quoted sources (that is, sources who were quoted about waiting times for medical services), while 19.2% referenced three. Table 15 compares across newspapers.

Table 15

Number and percentage of news articles by number of quoted sources and newspaper, from four Atlantic Canada daily newspapers (01/01/2003 to 12/31/2005)

Quoted Sources*	Newspaper # (%)			
	<i>The Chronicle-Herald/The Sunday Herald</i>	<i>The Guardian</i>	<i>The New Brunswick Telegraph Journal</i>	<i>The Telegram</i>
0	7 (6.4)	3 (4.8)	1 (1.5)	5 (6)
1	19 (17.4)	32 (50.8)	24 (35.3)	33 (39.8)
2	30 (27.5)	12 (19)	19 (27.9)	17 (20.5)
3	25 (22.9)	8 (12.7)	15 (22.1)	14 (16.9)
4	16 (14.7)	6 (9.5)	6 (8.8)	7 (8.4)
5	5 (4.6)	2 (3.2)	1 (1.5)	5 (6)
6	5 (4.6)	0 (0)	2 (2.9)	1 (1.2)
7	2 (1.8)	0 (0)	0 (0)	1 (1.2)
Total	109 (100)	63 (100)	68 (100)	83 (100)

* "Quoted source" refers to a source who was quoted about waiting times.

In terms of kinds of quoted sources, Table 16 provides the number and percentage of quoted sources by source type, which includes federal and provincial non-department of health government sources such as the prime minister, opposition politicians, and non-health sector politicians; provincial and federal department of health sources; physicians (which includes sources from national or provincial medical professional associations such as the Canadian Medical Association and the Newfoundland and Labrador Medical Association); health system managers and decision makers such as district (e.g., Nova Scotia) or regional (e.g., Newfoundland) health authority spokespersons, hospital chief executive officers, vice-presidents, or directors; patients and patient relatives (such as patient parents or spouses); other health care providers (mainly including nurse practitioners and provincial or national nursing professional associations); academic researchers; disease groups (such as a Canadian cancer society or an arthritis society); think-tanks and interest groups (most notably, the Vancouver-based right-wing think-tank the Fraser Institute); and research funding organizations (such as the Canadian

Institutes of Health Research). The total number of quoted sources (n = 847) exceeds the total number of articles (n = 407) due to reporting of more than one quoted source per article in some cases.

Table 16

*Number and percentage of quoted sources in news articles by source type, * from four Atlantic Canada daily newspapers (01/01/2003 to 12/31/2005)*

Kind of source	Number of sources	Percentage of total (%) (n = 847)
Other (non-health) FPT sources	205	24.2
Physicians/medical professional associations	156	18.4
FPT department of health	153	18.1
Health system managers/decision makers	75	8.9
Other health care providers/professional associations	45	5.3
Patients/patient relatives	45	5.3
Academic researchers	44	5.2
Disease groups	43	5.1
Think-tanks and interest groups	36	4.3
Miscellaneous	23	2.7
Research funding organizations	22	2.6
Total	847	100

*Up to seven quoted news sources were coded for each article.

Table 17

Number and percentage of quoted sources in news articles by newspaper and source type. from four Atlantic Canada daily newspapers (01/01/2003 to 12/31/2005)*

Source* (n = 847)	Newspaper # (%)			
	<i>The Chronicle-Herald/The Sunday Herald</i>	<i>The Guardian</i>	<i>The New Brunswick Telegraph Journal</i>	<i>The Telegram</i>
FPT department of health	66 (7.8)	24 (2.8)	34 (4)	29 (3.4)
Physicians/medical professional associations	52 (6.1)	25 (3)	35 (4.1)	44 (5.2)
Other health care providers/professional associations	13 (1.5)	5 (0.6)	21 (2.5)	6 (0.7)
Health system decision makers	28 (3.3)	6 (0.7)	29 (3.4)	12 (1.4)
Academic researchers	8 (0.9)	1 (0.1)	24 (2.8)	11 (1.3)
Think-tanks and interest groups	5 (0.6)	3 (0.4)	23 (2.7)	5 (0.6)
Research funding organizations	1 (0.1)	0 (0)	19 (2.2)	2 (0.2)
Disease groups	10 (1.2)	2 (0.2)	23 (2.7)	8 (0.9)
Patients/patient relatives	9 (1.1)	2 (0.2)	20 (2.4)	14 (1.7)
Other FPT sources	88 (10.4)	44 (5.2)	37 (4.4)	36 (4.3)
Miscellaneous	6 (0.7)	2 (0.2)	7 (0.8)	8 (0.9)

*Up to seven quoted news sources were coded for each article, therefore n = 847.

Kinds of Reported Evidence

Some of the articles relied on levels of evidence besides that which arose from discussions with quoted sources, news releases, and/or current events. Reported evidence included academic research, non-governmental organization (NGO) reports, government or government commissioned reports, and anecdotal evidence. Roughly five percent (21/407) of the articles reported research evidence; approximately 10% (40/407) reported anecdotal evidence;

and 16.2% (66/407) and 12.5% (51/407) of the articles reported NGO or government reports, respectively.

The most frequently quoted research evidence tended to come from the *Canadian Medical Association Journal*, including one study that showed parents with children suffering from vomiting and diarrhea left hospital emergency rooms before being treated because of long waits to see a doctor, and another that found both rich and poor patients encounter similar waits for certain procedures. In terms of non-governmental reports, the Fraser Institute and the Wait Times Alliance were the most frequently cited sources, with the Fraser Institute getting slightly more coverage overall. While government reports tended to include department of health data, there was also frequent coverage of the Romanow commission and the Kirby reports. Finally, anecdotal evidence focused on individual cases, which may be atypical as in this front-page example:

A Charlottetown man who waited over three hours in a hospital emergency room — bleeding so badly he filled three plastic containers — was told he would have to go to Summerside, 71 kilometres away, to be treated. Forest Fall said he was outraged by the way he was treated at the Queen Elizabeth Hospital. He said waiting times at the province's largest referral hospital are getting so long that people's lives are being jeopardized. "I'm starting to panic," Fall said, as he recounted his ordeal, still fresh in his mind months after it happened. "I'm not knowing what's going on. I don't know why I'm bleeding. Nobody is telling me anything" (Thibodeau, 2004b).

Table 18

Number and percentage of articles by level of evidence and newspaper, from four Atlantic Canada daily newspapers (01/01/2003 to 12/31/2005)

Evidence	Newspaper # (%)			
	<i>The Chronicle-Herald/The Sunday Herald (n = 145)</i>	<i>The Guardian (n = 79)</i>	<i>The New Brunswick Telegraph Journal (n = 84)</i>	<i>The Telegram (n = 99)</i>
Research	7 (4.8)	2 (2.5)	4 (4.8)	8 (8.1)
NGO reports and data	22 (15.2)	11 (13.9)	12 (14.3)	21 (21.2)
Government reports, royal commissions, and other data	29 (20)	4 (5.1)	16 (19)	2 (2)
Anecdotal	13 (9)	2 (2.5)	6 (7.1)	16 (16.2)

News Topics

The articles discuss a variety of topics about waiting times for medical services. In particular, they discuss different kinds of services — primarily joint replacements, followed by diagnostic services, cancer, and cardiac care, but also sight restoration, autism, arthritis, and addiction services. It is important to note that total services reported exceed the total number of articles due to reporting of more than one service per article.

Table 19

*Number and percentage of articles that discuss a particular health service by service and newspaper, * from four Atlantic Canada daily newspapers (01/01/2003 to 12/31/2005)*

Service	Newspaper # (%)				Total
	<i>The Chronicle-Herald/The Sunday Herald</i> (n = 145)	<i>The Guardian</i> (n = 79)	<i>The New Brunswick Telegraph Journal</i> (n = 84)	<i>The Telegram</i> (n = 99)	
Joint replacement (hip and knee)	69 (48)	29 (37)	33 (39.3)	41 (41.4)	172
Diagnostic services (CT or MRI)	32 (22.1)	20 (25.3)	19 (22.6)	37 (37.4)	108
Cancer care	45 (31)	25 (31.6)	17 (20.2)	32 (32.3)	119
Cardiac care	43 (30)	24 (30.4)	21 (25)	31 (31.3)	119
Sight restoration	12 (8.3)	10 (12.7)	11 (13.1)	13 (13.1)	46
Other (autism, arthritis, addiction)	4 (2.8)	2 (2.5)	4 (4.8)	9 (9.1)	19

*These numbers represent the number of articles discussing each service, but do not capture the number of articles discussing a combination of services.

Thematic Analysis

Until this point, I have presented mainly quantitative information. In this section, I present the constructed knowledge that came from my analysis as a series of themes and sub-themes. Ryan and Bernard (2000) point out that a “widely used method for describing themes is the presentation of direct quotes from respondents — quotes that lead the reader to understand quickly what it may have taken the researcher months or years to figure out” (p. 784). I have selected segments of text (that is, verbatim quotes from my sample) as exemplars of my themes. I have also reserved a section at the end of this chapter to highlight topics that received minimal news coverage.

Major Themes

There were four prominent themes that arose from my analysis: (1) waiting times are indicative of inadequate resources within the health care system; (2) the health care system is in a state of crisis due to long waits; (3) there is an ongoing debate over the impact of public versus private health care on waiting times; and (4) greater managed care techniques are the starting point for improving waiting times, but there is confusion over which techniques are best. In this section, I provide examples of these themes and sub-themes. In some cases, I also provide examples of outliers, that is, examples that are contradictory to the themes.

Theme I: Waiting times indicate inadequate resources within the health care system

Waiting times are predominantly conceptualized as indicators of inadequate resources within the health care system. In accordance with this conceptualization, the predominantly proposed solutions involve increasing available resources, including financial resources, health human resources, and overall infrastructure. One common word comes to mind for each of these solutions — “more” money, “more” providers, “more” technology, “more” infrastructure, etc. In fact, when it comes to improving waiting times and waiting lists, adding more (it would seem) of everything to the health care system is the primary suggested solution. Interestingly, although the options for what resources to increase varies (for example, from adding more equipment to hiring more staff), reports often focus on a single option.

Sub-theme I: Greater fiscal leverage and management of public funds will improve waits

More funding to reduce wait times would address real need in N.B. . . Doctors’ demands for billions more in federal funding to target wait times would benefit New Brunswickers,

says the president of the province's medical society. Dr. Lyle Weston said Thursday funding demands by his provincial and national counterparts that would target wait times could alleviate pressures on the health care system. (Chiarelli, 2005)

Provinces, Ottawa reach \$18-B deal

First ministers completed an agreement Wednesday that will see the federal government pump an additional \$18 billion into medicare over six years. . . The agreement will mean a federal investment of \$41.2 billion over 10 years with an escalator clause to account for spiralling increases in health-care costs. . . Previous federal-provincial health-care agreements in 2000 and 2003 did nothing to quell persistent demands for more money as provinces struggled to fund cash-starved health systems. (Panetta, 2004)

Outliers

Money is not always the solution. ("Money is," 2005)

More money, bigger bureaucracy won't solve health-care woes. (Esmail, 2003)

Sub-theme II: Purchasing high-tech health care equipment will improve waiting times

MRI money coming Monday

Premier John Hamm will be in Kentville on Monday to announce the province will spend millions on new equipment to reduce wait times for MRI tests, one of his priorities for new federal health money. (Jackson, 2004)

New Brunswick's health minister has announced \$1.9 million in funding for equipment that will reduce wait times for heart patients in the province. Elvy Robichaud said Tuesday the money will be used to add a third cardiac catheterization unit at the New Brunswick Heart Centre within the Saint John Regional Hospital. The new unit will allow the centre to serve an extra 700 patients a year. The minister also pledged \$500,000 to establish an advanced cardiac electrophysiology unit at the regional hospital, the first of its kind in New Brunswick. ("New funding," 2005)

Outlier

Province's second MRI will soon be ready to go: But officials warn it won't solve wait-list problem . . . The new magnetic resonance imaging (MRI) machine at Western Memorial Regional Hospital will soon be receiving patients, but it is just one more step towards solving lengthy wait lists for the test across the province. . . "We still need two more — one in central and a second in St. John's — and we all agree that needs to happen," said Mercer. (Kean, 2005)

Sub-theme III: Strengthening the health care workforce will improve waiting times

Doctors want feds to put up \$1B to tackle shortage. ("Doctors want," 2004)

Human resources are key to health care . . .

Health human resource planning is essential and must be addressed if the government is truly committed to reducing wait times and increasing accessibility to health-care services. (Simms, 2005)

Federal Health Minister Ujjal Dosanjh says medical schools must move more quickly to create spaces in medical schools. During a visit to Halifax, the federal minister told reporters that getting professionals into Canada's health system remains key to reducing wait times for patients. . . Dosanjh says more work needs to be done to increase the numbers of doctors and nurses across the country. He says there's still a need for more hospital residency positions, both for Canadian-trained doctors and international medical graduates. ("Medical schools," 2005)

Sub-theme IV: Opening health care institutions (altogether or for longer hours) and/or making more beds available will improve waiting times

The Capital district health authority opened 21 hospital beds for long-term care Monday. Plans to open the beds, in Unit 4B of the Queen Elizabeth II Health Sciences Centre's Centennial building, were announced in January. The move was part of a 10-point plan to ease overcrowding in the QEII's emergency room. ("Capital district," 2004)

Plan "not going to fix" ER woes; Nurses, doctors fear biggest problem — lack of inpatient beds — still not addressed . . . NSGEU president Joan Jessome said the union didn't get the two things it wanted most. "We need additional beds and there needs to be a process put in place on how people are admitted to the ER." (Arsenault, 2004a)

Surgeons hold blitz to reduce waiting list

Orthopedic surgeons teamed with nurses and anesthetists at the QEII recently to make a dent in the enormous waiting list for total joint replacement with a two-week surgical blitz. By borrowing nurses from other units and using every available operating session, the doctors were able to perform 122 hip and knee replacements between Nov. 28 and Dec. 9. Normally, the surgeons at the Queen Elizabeth II Health Sciences Centre in Halifax can only complete about 100 joint replacements per month. (Gillis, 2005)

Outlier

“It would be nice to assume that rushing off and providing a whole bunch more operating rooms is the right solution.” But it isn’t that simple, he said, because co-ordination is vital, since surgery requires anesthetists, post-operative recovery and support staff to operate.

“It's a fairly complex thing.” (Arsenault, 2003)

Theme II: Crisis and long waits

Waiting times are often conceptualized as being too long and — further to this — the crux of a health care system and patient safety crisis. The dialogue is framed as health care being in or on the verge of crisis with waits and waiting times being referred to in a variety of ways, including as being “on the rise;” as causing us to “lag far behind” in performance; as causing “intolerable” suffering to patients; as growing “like a cancer;” and as creating “backlog” in an already “ailing” health care system. In some cases, the headline implies the health care system is in crisis, as in these examples:

Over 450 wait for help with mental health; MLA: Situation in metro a crisis. (Jackson, 2005a)

Halifax: Emergency waits reaching 12 hours. (The Canadian Press, 2003)

N.S. waiting list for mental health care at crisis level. (The Canadian Press, 2005c)

Clinic struggles to deal with waiting list. (Davis, 2004)

Radiologist collecting waiting list horror stories. (Stokes Sullivan, 2003b)

More rheumatologists needed: society: (sic) Says arthritis-care crisis will grow unless more specialists hired. (Connors, 2003)

Man left bleeding at QEH for three hours. (Thibodeau, 2004b)

Two-year wait: Children`s hospital can`t keep up with MRI demands. (Stokes Sullivan, 2004)

And other examples include:

The “crises” in health care . . . You can`t even talk about health care in Canada anymore, it seems, without a mandatory mention of the word “crisis.”. . . There`s a “crisis” in waiting times for umpteen surgical procedures. Shortages of doctors, nurses, technicians and other health care workers are at “crisis” levels; and, on top of that, looming retirements in all medical disciplines will, we`re told, exacerbate that “crisis.” The need to update, replace and repair aging medical equipment and infrastructure has also hit a “crisis” point. (“The ‘crises,’” 2005)

“Access denied”: Newfoundland “dead last” in industrialized world for MRI wait-lists . . . Normand Laberge, chief executive officer of the Canadian Association of Radiologists,

says he was astounded last week after reading a Telegram story about Ryan Oldford, a four-year-old boy who lost a kidney to cancer in June 2003, and now has to wait 2 1/2 years for a magnetic resonance imaging (MRI) scan on his other kidney. “Two years and a half is access denied. This is no longer a wait-list, and mind you he had to wait three or four months before the hospital called, so there’s a wait-list for the wait-list,” Laberge said Thursday. “That’s just not acceptable. There’s no guidelines in the world that would say that this is proper in terms of health care.” (Stokes Sullivan, 2005a)

The state of our health care in Newfoundland and Labrador is appalling.

I had to take a moment to vent my frustration to my fellow Newfoundlanders as all our health is at stake. So far, I have been waiting 12 months to see him [the specialist] and, as his secretary stated, “the wait list is usually, or about, two to two and a half years.” . . . Hearing this is quite scary. This problem has already affected my schooling and various other aspects of my life. Yet, I am forced to wait patiently for an opening on a list while I cannot even be told the position that I hold on it. (Rolls, 2003)

Outliers

Report off on MRI wait times: Health Care Corp. says Newfoundland on par with most Canadian provinces. (“Report off,” 2004)

Waiting time not a factor in deaths. (The Canadian Press, 2004b)

Wait times report flawed, health minister says. (Stokes Sullivan, 2005b)

MRI wait times shrinking; Shortage of technologists may reverse trend. (Arsenault, 2004b)

Theme III: Public/private health care debate

Increasing access to private health care is often suggested as a solution to end long waits. This idea was a particular focus of discussion and debate in 2005, prompted in large part by the Supreme Court of Canada's ruling in the Chaoulli-Zeliotis case. While some (including many physicians and their professional associations and the Fraser Institute, among others) made the case for a private (or, more specifically, two-tier) system as a solution, others (primarily politicians and a few researchers) sided with Canada's public system.

[Canadian Medical Association (CMA)] backs away from rejecting private health care Delegates to the Canadian Medical Association annual meeting backed away Tuesday from taking a stand against private health care, opening the door to what some fear will be a road map to privatization. Doctors voted down a resolution by a two-thirds margin that called on them to reject the private way as the solution to long wait lists for services in the public system. However, they did agree overwhelmingly that access to medical care should be based on need, not the ability to pay. (The Canadian Press, 2005d)

Private clinics could help ease health-care congestion — Bouchard; “Quebec's public finances are disastrous,” former premier says. (The Canadian Press, 2004c)

Don't demonize two-tier system, think-tank warns. (Thomas, 2005)

Martin defends single-tier health care. . . Prime Minister Paul Martin insists that access to health care should be based on need rather than ability to pay, despite a Supreme Court decision that suggests the contrary. . . “I don't believe in a two-tier medicare system,” Mr.

Martin told the . . . audience. “What we’re doing is putting our money into strengthening the public health-care system. The way you avoid all of the problems of a two-tier system, which we see in the United States, for example, every single day, is to make sure your public health-care system is very, very strong.” (Bueckert, 2005a)

Dosanjh says two-tier system will create longer wait times . . . Health Minister Ujjal Dosanjh says a parallel private health system would not result in shorter wait lists and some of Canada’s leading health policy experts agree. “Private care is absolutely not a panacea (for long waits),” Dosanjh said Tuesday. (Bueckert, 2005b)

Theme IV: Greater managed care techniques are the starting point for improving waiting times, but there is confusion over which techniques are best

Better waiting list management techniques are suggested for improving waiting times for medical services. The most popularly suggested techniques involve discussions around the creation of national standards or benchmarks and discussions of maximum waiting time guarantees. Discussion of these techniques were particularly present in 2005, as the First Ministers aimed to reach their December 2005 goal of proposing waiting time targets or benchmarks in five priority health care service areas. To a lesser extent, travel options for relocating patients who have been waiting too long were also discussed. And lesser still are suggestions to centralize waiting lists. Although there is much discussion, there remains confusion over the best option. Take this debate on guaranteed waiting times for example:

Martin drops notion of care guarantees . . . Paul Martin . . . has stopped short of offering “care guarantees” that he advocated before becoming prime minister. Under a care

guarantee system, the government would set maximum waiting times for key medical services, and if the time limits could not be met in the patient's home province, the patient would be sent to another jurisdiction. Martin endorsed the idea last year. In April, he told an Alberta newspaper, "provincial governments need to guarantee medical procedures within a specific period of time or be willing to send patients to other provinces for operations." The Liberal health platform announced Tuesday promises to define maximum waiting times for five key procedures, and meet those targets by the end of 2009, but there is no commitment to send patients to elsewhere if the target can't be met. . . attempts in Britain and Sweden to set national standards for acceptable waits worked only in the short term, and produced some paradoxical effects. For example, implementation of a U.K. patient charter, guaranteeing service within set times, did clear backlogged patients, but at the same time caused waits among other patients to increase. Michael Rachlis, a physician who has written extensively about health policy, said the problem of waiting lists can be solved through better organization of existing resources. He cited the case of a Saskatchewan doctor working with two nurse practitioners who is managing twice as many patients as the average doctor, suggesting that widespread use of this model would cut the need for new doctors. (The Canadian Press, 2004d)

Grits call for guaranteed wait times; If province can't meet targets, send patients outside — critic The Liberals say Nova Scotians should have a guarantee that certain health-care procedures will be done within a set time or the province will pay for patients to be treated elsewhere. . . Mr. Wilson, the Liberal health critic, said there should be a maximum period that patients are expected to wait for particular procedures. "Once

established, these time frames would be used as targets,” he said. “If the procedure is not available within this time frame, the patient will be sent, if he or she agrees, to another province or another country to receive the treatment at no cost to the patient.” (Smith, 2004)

. . . the medical profession has no interest in setting up a system that lets provinces set their own varying standards for what constitutes an unacceptable wait. “A waiting period in P.E.I. is the same as a waiting period in Toronto or Prince George. The effect on the patient is the same,” she said. Collins-Nakai and the CMA are proposing a system that would set bench marks for waiting times in a patient’s home province. Once the mark is reached, health planners would be able to look for whichever province can accommodate the patient’s needs. (Ryder, 2005)

Minor Themes

The themes in this section were less prominent than those already discussed and are (1) discussions of waiting times are often used as a segue into other health care discussions; (2) although collaboration is described as key to improving waits, support for working together is wavering and exists among a select group of key players; and (3) waiting times are discussed in terms of values and principles such as equity and fairness.

Theme I: Discussions of waiting times are used as a segue into other health care discussions

Although the headline or lead of a news article may indicate an article is about waiting times for medical services, sometimes this is not the case. In fact, sometimes the headline and first two paragraphs are the only parts of the text that refer to waiting times, with the remainder of the

document focused on such issues as a new pharmacare program, a looming political election, or the public-private health care debate.

Liberals demand apology from NDP leader after he accuses PM of causing deaths of patients on hospital waiting lists . . . Opposition leaders smelled blood on the federal campaign trail Thursday, accusing Prime Minister Paul Martin of causing the deaths of homeless Canadians and risking the lives of the country's soldiers. Mr. Martin and his Liberal colleagues reacted with outrage as the campaign dissolved into attacks and counter-attacks less than a week after it began. (Cordon, 2004)

Prime Minister Paul Martin poured cold water Thursday on the proposal that Ottawa take full responsibility for a national pharmacare program, suggesting the recent idea from the provinces is overly simplistic and ignores priorities such as waiting lists . . . Canada's premiers demanded Ottawa develop and pay for a new nationwide pharmacare program to cover the cost of prescription drugs. The premiers had gathered to plot strategy for a mid-September conference with the prime minister on the future sustainability of the health care system. (Curry, 2004)

Theme II: Collaboration is the key to improving waits, but support is wavering and there is a select group of key players

When it comes to "key" players working together to improve waits, the relationship is described as being of the on again-off again variety at best. And the players are limited, with representation mainly from federal, provincial, and territorial governments (including department of health representatives) and physicians and their professional associations. Although these players are

represented as recognizing the need to work together, they also seemingly complicate one another's lives with low blows and blame games. Take these headlines for example:

Premiers prepare for a little Ottawa arm-twisting. (Stephenson, 2004)

Provinces prescribe timelier treatment; Ottawa won't withhold cash to enforce shorter wait times. (Jackson, 2005b)

Top doctor deplures lineups: Demands politicians commit to timely access to health care. (Crawford, 2004)

Medical groups attack government backtracking on wait-time benchmarks. (Bueckert, 2005c)

Ottawa, provinces must invest \$3 billion in health care: doctors. (The Canadian Press, 2005e)

Theme III: Waiting times are discussed in terms of values and principles such as equity and fairness

There is some talk of values in discussions of waiting times for medical services. Among the main "values" topics that arise are accountability and transparency, comprehensiveness, equity, and fairness.

Governments should publicly state appropriate wait times for medical services and regularly report on how they're meeting their goals, says Health Minister Pierre Pettigrew.

In his first major speech on health since assuming the portfolio, Mr. Pettigrew said Tuesday better accountability is vital to improve medicare. "Canadians have a right to know what acceptable wait times are for different types of services and procedures, what

level of care they should expect, whether their local providers are doing better or worse than the norm, and why,” he said at a conference on health reform. (Bueckert, 2004)

Rich or poor, waits for surgeries still long; Results of study “reassuring” that health system is fair . . . “In a system of mixed private and public, and people buy their way to the front of the line, equity isn’t an issue. That’s not what the goal of the system is. But so long as there is this effective monopoly, we have to be sure that we’re being fair to everybody and not discriminating on the basis of social position. And we’re happy in this instance we’ve shown that.” (Branswell, 2003)

Under-represented Topics

In qualitative analysis, what one does not find can be an important as what one does find. In this section, I present topics (and sub-topics) that were, in my opinion, lacking from the dialogue on waiting times for medical services. These topics arose from a comparison of the newspaper documents in the study sample and the published literature on wait times for medical services.

Topic I: Waiting times are measures of access to quality care

Waiting times have also been conceptualized as measures of access to care. To a lesser extent, these discussions are about access to quality health care. Even then, there is no attempt to define what we mean by quality. Take this example:

Health-care funding key issue in race for Charlottetown seat: Four candidates agree accessible, quality health system is priority, but all take different approaches to financing it. . . NDP candidate Dody Crane says health funding is a question of will as much as money. “But when you talk about medical services and ask if people would be willing to

pay more taxes to get them, they say yes,” she said. . . “People are willing to pay for quality services. It’s just a question of asking them what they want to do.” “I think every Canadian has a right to health care that is accessible, publicly funded and top quality,” he said. (Ryder, 2004)

Topic II: Portrayals of patients who are content with their health care service

What are lacking in the anecdotal evidence are stories from patients who are content with their service. Such stories tend to arise in letters to the editor. They also appear in news articles as “exceptions to the rule” that patients are generally discontent with health care. Take this example from a patient who was happy with the services received:

Cancer patient thankful for medical system. (“Cancer patient,” 2003)

Topic III: Important contextual information around waiting times is lacking

Important contextual information — such as how to define waits and how much health care costs — are lacking from newspaper coverage of waiting times for medical services.

Sub-topic I: There is little sense-making of health care dollars and cents

There is no contextual information in terms of how much health care costs and, therefore, what thousand, multi-million, or billion dollar expenditures mean in terms of improving waiting times.

Sub-topic II: Waiting times are defined in different ways

Waiting times are defined in a variety of ways, but news coverage gave minimal insight into this fact, with the exception of two articles.

In admissions management, those waiting for hospital care are divided into groups according to their conditions and the services they need such as brain and spinal cord surgery, heart care, problems of the ear, nose and throat and diseases of the bones and joints. Continuing assessments by the patients' doctors provide the up-to-date, reliable basis for admission to the hospital's medical and surgical services. (Warwick, 2004)

Deputy health minister Tom Ward knows the system needs changing. "It's just such a grab bag," Mr. Ward said. "Individual physicians keep their wait lists, and how they prioritize patients on their wait lists varies." He said some doctors may start measuring wait times from the moment of injury while others start theirs at the time of diagnosis. (Arsenault, 2003)

Chapter Summary

In this section, I have shared my study findings, which included an overview of the general characteristics and themes from newspaper documents on waiting times for medical services from four Atlantic Canada daily newspapers. In the next chapter, I hypothesize as to the possible explanations for these results.

CHAPTER FIVE: DISCUSSION

In this final section, I attempt to make sense of my findings, proposing my own inferences and explanations. In particular, I draw attention to the major trends and patterns of the findings and, in some cases, to the exceptions, all the while considering the likely causes underlying these. Overall, I aim to draw explanations that tie in the background and literature I have laid out, ultimately showing the relationship of my results to my original research objectives, which are (1) to describe the general characteristics and themes that arise from Atlantic Canada daily newspaper coverage of waiting times for medical services over a specified time period and against a backdrop of the policy changes and research developments that occurred in that period; (2) to compare and contrast the characteristics and themes that arise across four specific newspapers and over the time period specified; and (3) to make informed assertions about how news coverage of waiting times can influence the public's knowledge of health services and Canadian health policy regarding waiting times for medical services.

Discussion of Sample Characteristics and Themes

Given that the majority of health news in Canadian newspapers tends to be about the health care system (Hayes et al., in press) and that improving health care waiting is a top health care priority for Canadians, it comes as no surprise that waiting times are a frequently explored topic in health news articles and opinion pieces in Atlantic Canada daily newspapers. Perhaps one of the reasons waiting lists are so frequently covered is because they are recognized as easily understood indicators of the stability of the health care system. The frequency of health care waiting times is particularly clear from the large number of newspaper documents collected over the study period from four Atlantic Canada daily newspapers (January 1, 2003 to December 31,

2005).. In the section on implications, I consider what news reporting on health care implies about how the news media, journalists and, in fact, newsmakers perceive health.

Also not surprisingly, most of the articles (183/407, 45%) in the sample were retrieved from 2005 — a year when a number of significant health care events took place that are relevant to waiting times, not the least of which was the realization of national waiting time benchmarks (evidence-based standards) for priority health care services in December 2005 and the wide public debate over the future of medicare, as a result of the now infamous Chaoulli decision in June 2005.

What do story prominence and number of quoted sources tell us?

Considering the assemblage of patients, the public, health care providers, and policy and decision makers interested in health care waiting times, it also makes sense that newspaper articles covering waits tend to be highly prominent. With half of the articles in the sample published in the newspapers' front sections (204/407, 50.1%) (and 65/204 or 16% of these showing up on the front page), health care waiting times are clearly a newsworthy topic. However, one must consider the possibility that the number of front-section news articles may also be a by-product of the data collection strategy, which may have unfairly favoured the collection of news articles (which are more likely than other documents to refer to waiting times in the headline or lead). For example, a search strategy that searched the whole text may have yielded a higher number of opinion pieces. In any case, story prominence is by no means a perfect variable, as I explain in more depth in the limitations section of this chapter.

There are several other indicators that are telling of story prominence, including the substantial word lengths of the articles in the sample and the fact that 22.1% of articles (90/407) featured a photo. Typically, photos are thought to raise the profile of a news article, as they draw

the reader's attention to the story. In the same way, a lengthier article is thought to be more prominent, as it is afforded more inches on the newspaper page.

The largest and smallest newspapers (*The Chronicle Herald* and *The Guardian*) featured the most photos (46/145, 34.1% and 21/79, 26.6%, respectively), as well as the most number of news articles that were both on the front page and with a photo. For *The Chronicle Herald*, this scenario makes sense. Since this daily has the greatest number of staff reporters contributing to stories on waiting times (with 50 out of 109 or 45.9% of this newspaper's articles written by staff reporters), one might also expect it to have a high number of staff photographers. Of course, only an analysis of illustration bylines (which was beyond the scope of this study) could support this hypothesis. Reversely, *The Guardian* may pick up a number of newswire photos since their staff reporter count (5 staff reporters according to this analysis versus 14 at *The Chronicle Herald*) indicates a sizable decrease from *The Chronicle Herald*. One must keep in mind, however, that the number of staff reporters and photographers does not necessarily correlate with the number of health stories and/or pictures. Another explanation why these newspapers feature more front-page news articles and photos (than *The New Brunswick Telegraph Journal* or *The Telegram*) is that these stories about health care waiting times have greater resonance with their readers.

When it comes to the number of quoted sources, *The Chronicle Herald* also featured the highest number per story (with most articles averaging two to three quoted sources). Given the high staffing at this newspaper (and therefore, greater ability to invest staff time into high-profile stories), it makes sense it would feature more quoted spokespersons than others (which averaged 1 to 2 quoted sources per article). At the same time, *The New Brunswick Telegraph Journal* had the highest staff count but featured fewer quoted spokespersons per story. Perhaps the difference is that *The Chronicle Herald* has at least two health reporters (and one provincial reporter, David

Jackson, who also contributed a number of waiting times news articles), whereas *The New Brunswick Telegraph Journal* did not identify health reporters in their reporter bylines. For the purposes of this study, health reporters were identified by having “health reporter” or some equivalent listed in an article byline. However, “some newspapers list their reporters by beat when in fact they are not full-time on the beat[;] . . . they [only] do health stories from time to time when they come up on their beat ([for example], provincial and municipal beats)” (M. Cobden, personal communication, February 22, 2007). In any case, one hypothesis is that specialized (in this case, health) reporters likely have a better understanding of which sources to quote. One way to explore this hypothesis is to compare and contrast the number of quoted sources per story in articles written by health reporters versus those written by other staff, which was beyond the scope of this study.

Overall, the large number and prominence of news articles on waiting times for medical services seems to indicate this topic is a highly newsworthy one in which Atlantic Canadian newspapers are willing to invest their resources.

Who is reporting on waiting times and what does this tell us?

As already mentioned, *The New Brunswick Telegraph Journal* and *The Chronicle Herald* identified the highest number of staff reporters. However, only *The Chronicle Herald* and *The Telegram* identified staff health reporters in article bylines (2 and 1 health reporters, respectively). Although all newspapers did not identify health reporters, this is not to say they are without; rather these were not captured in my analysis, where health reporters were identified by byline attribution. Also, some newswire reporters (such as Dennis Bueckert, Sheryl Ubelacker, and Amy Smith) “appear” to be health reporters (which my analysis did not capture), given the number of stories they contributed on waiting times for health services. These newswire

reporters, along with the three identified health reporters (Dan Arsenault, John Gillis, and Deana Stokes Sullivan), accounted for nearly 26% (83/323) of the overall number of news articles. However, that leaves a significant number of news articles written by other staff reporters, who may not fully comprehend the complexity and density of the issues surrounding waiting times. Further studies may wish to explore this hypothesis in some depth.

Why do most stories have a negative tone and what does this tell us?

News media coverage of health care waiting times has typically received much criticism from the research community for being overly negative and sensational (see McDonald et al., 1998; Sanmartin et al., 1998; Barer & Lewis, 2000). However, this news media representation study is the first (that I know of) to explore news coverage of waiting times for medical services. Although most (187/407, 46%) of the articles in the sample had a negative tone, 38% (154/407) and 16.2% (66/407) had a neutral and positive tone, respectively. To clarify, a negative tone indicated the news article referred to waiting times as increasing or worsening; a positive tone indicated the news article referred to waiting times as decreasing or improving; and a neutral tone indicated the news article gave no reference to whether waiting times were decreasing and improving or increasing and worsening. With these definitions in mind, I will explore possible explanations for why most of the stories in my sample had a negative tone.

In the same way that a story of an airplane landing safely is a rarity in the news media, so too is the story of a patient who obtains timely access to care. From a journalism perspective, the story of a plane crashing is news for many reasons: it does not happen often, so it meets the criterion of unusualness; it is relevant to readers who fly; and it calls for an explanation to assure the public that the crash was not due to incompetence or negligence on the part of the authorities (M. Cobden, personal communication, February 22, 2007). In a country like Canada, where

things are assumed to run efficiently, “news” happens when things fail to run efficiently (M. Cobden, personal communication, February 22, 2007). Turning to the case of waiting times, “people are assumed to be able to get treatment without waiting longer than the society thinks reasonable ([for example], waiting two years for a knee replacement) [and i]f they [are not] able to get treatment within a time the society judges reasonable, it’s news” (M. Cobden, personal communication, February 22, 2007).

Also from a journalism perspective, the story of a patient waiting for health care is not an isolated event, but part of an ongoing narrative about access to care. Journalists are, in fact, expected to report instances in an effort to represent the whole: “the news media should report instances of people waiting two and half years for a knee replacement [but t]hey would probably stop reporting this if it happened every day, though they [should not stop]” (M. Cobden, personal communication, February 22, 2007). However, this tendency to report exceptions — in this case, to efficiency and access in health care — can create problems:

In crime reporting, for example, there is an irony that probably applies to the issue of waiting times for treatment. If violent crime is uncommon in a community, whenever it happens it’s big news — which makes people think that it’s more common than it is. The reverse is also true. (M. Cobden, personal communication, February 22, 2007)

For researchers who study the subject of waiting times and policy and decision makers who work in the health sector (among others), the news media’s tendency to report negative exceptions can create a false impression of the health care system. In the same way, this kind of reporting can lead news media audiences to believe health system managers and policy makers ought to spend more time and resources improving access versus on other factors that also influence the quality of health care and impact the health of individuals and populations. Researchers and others may

feel slighted by news media coverage of waiting times, which does little to showcase progress on waiting times, which I discussed in chapters one and two.

Overall, from a journalism perspective, it is legitimate (and, in fact, responsible journalism) to scrutinize the way power is exercised and report the negative cases of access to care; however, from the research and decision-making perspective, this kind of reporting can create undue anxieties about the state of Canada's publicly funded health care system.

What do the kinds of reported evidence tell us?

In this study, anecdotal evidence was reported in only one of every 10 stories (40/407, 10%). Once again, this finding may be a by-product of the study's inclusion criteria, which may have resulted in fewer articles with anecdotal leads (which, by their nature, may not refer to waiting times in the headline or lead).

Although those who live the health experience are seldom regarded as experts, arguably those who are on waiting lists are experts on their own situation (Seale, 2003). From this perspective, it is reasonable for the news media to report individual people's experiences. The logic of journalists choosing to report anecdotally works as follows:

Anecdotes are stories; stories are more readable than exposition and are therefore more successful in informing readers. This is especially true when it comes to the literature of policy, government reports, research reports, etc., which journalists know their readers will find difficult to understand. Instead of reporting this material directly in its own expository language, they tend to look for anecdotes to make the material easier for the reader to understand. (M. Cobden, personal communication, February 22, 2007)

In this study, when anecdotal evidence was reported, it primarily profiled negative exceptions to access to care. For example, take the case of the bleeding man who was asked to

travel to another hospital, after having already waited in the first hospital for hours (Thibodeau, 2004b). This example is not an everyday occurrence, which in journalism terms, makes this story newsworthy. However, health system managers and policy makers may feel that focusing a news article on this kind of anecdote gives an unfair portrayal of health care waiting times, sends the wrong message about the state of the Canadian health care system, and ultimately is a distortion of real events.

But good journalism will rely on more than one anecdote to tell a story; it will balance the anecdote of the man waiting for care with anecdotes to the contrary and facts about waiting times from such resources as hospital or health authority reports, research, and other data (where such evidence exists and is accessible).

Meanwhile, the strongest form of evidence — research evidence — was reported the least (21/407, 5.2%), which is in line with Seale's (2003) argument that the media would cease to be popular if they reported more heavily on research evidence. Of course, if research evidence was well-understood, accessible, and made a "good story" (as was explained in chapter one), then this form of evidence might receive greater news media coverage.

Non-governmental organization (NGO) reports and government (including government commissioned) reports were reported more than three and two times as much as research evidence (66/407, 16.2% and 51/407, 12.5%, respectively), possibly because these people are more often in the news and more accessible to reporters than academics. The Fraser Institute was the most frequently cited source for NGO reports, which is interesting given its political leanings, but not surprising given its investments of time, money, and energy into communicating its messages to the news media. Not far behind the Fraser Institute were reports by the Wait Times Alliance, which (as I will explain further in the next section) is also not

surprising given this group is comprised of physicians and their professional associations. Meanwhile, the Romanow report was the most frequently cited government (commissioned) report.

In the end, a good job of informing the public about waiting times for medical services would include all of these levels of evidence. Of course, if research evidence in particular is to inform news media reporting, then this evidence must be accessible to journalists. In other words, incorporating all of these levels of evidence in news media coverage of health care will require efforts from those in a position to help journalists understand the evidence well enough to use it in their own stories. I will discuss this in greater depth later in this chapter.

Who are the quoted sources in news reports and what does this tell us?

In the same way that there were more frequently reported types of evidence, there were also more frequently photographed and quoted persons. Interestingly, while there are similarities in terms of which groups were most frequently photographed or quoted, there are also notable differences.

The most frequently quoted sources on waiting times were FPT non-health department government sources (205/847, 24.2%). The next most frequently quoted sources were physicians and their professional associations (156/847, 18.4%), followed by FPT department of health representatives (153/847, 18.1%). The most frequently photographed persons were also FPT representatives (68/115, 59.1%), (16/115, 13.9%) and non-physician health care providers (14/115, 12.2%).

Perhaps the reason physicians and FPT government sources were so frequently quoted is because they are perceived (by the news media and the public) as being the most knowledgeable or most authoritative on the subject of waiting times. From a journalism perspective, these

sources may be considered reliable for adding opinion and debate around the subject of improving waiting times. In addition, these sources have messages they want to be heard, so they likely are willing to invest more time and energy than others into talking to the media. For example, it may be that (in addition to the news media seeking these sources out) these kinds of sources are persistent and have developed strategies for getting their messages into the news media. This argument would also explain why nurses and their professional associations are the most frequently quoted persons in the “other health care provider” category, as this group is also likely to have time, money, and energy to invest into news media messaging.

FPT government sources are also the most frequently photographed group. Perhaps this is explained by the fact that politicians gain a kind of notoriety from always being in the public eye and, therefore, their images draw the readers’ attention to news. Given that politicians are always in the public eye, another explanation is that politicians are more accessible than other subjects to be photographed.

Meanwhile, the reader can sympathize with photos of patients, which may be why we see more photos capturing images of patients (than physicians, for example). In the same way (and in the way that a “picture is worth 1,000 words”), these photos can tell a reader the entire story. For example, by looking at a photo of a patient suffering or waiting, the reader has a better sense of what the news document is about. The same can be said of images of other health care providers, including nurses and technologists. For example, images of these providers attending a patient or using medical equipment can quickly indicate the crux of a news article to the reader.

Overall, the fact that some sources are quoted more than others may indicate these sources are perceived (by the news media and the public) to be more knowledgeable about waiting times than others. The fact that there is some discrepancy in who is quoted versus who is

photographed may simply indicate a discrepancy in what print reporters and photographers aim to achieve — telling a story through text versus through a lens.

What do the major and minor themes tell us?

What do the major themes tell us?

Four major themes came from my qualitative analysis. The first of these would have us believe that when it comes to improving health care waits, the best remedy is to get more of the same — more money, more staff, more technology, and more infrastructure. Each of these tangibles is proposed as a solution to end long waits. In the same way, a lack of these is presented as the root of the problem that long waits pose. But the research evidence is clear that there is no simple prescription for improving access to care, why do we keep hearing about these quick fixes in the news media?

Consider the sources — primarily FPT government sources and physicians and their professional associations — who are talking about waiting times for medical services. Perhaps sources offer simple solutions as a way of taking the heat off of themselves and, consequently, putting it onto others. Take the example of the federal health minister calling for medical schools to train more physicians, or the examples of physician professional associations and provincial and territorial governments calling for the federal government to put more money into health care. These diversions may be intended to confuse the subject of how to (and who should) improve waits. But given there is no easy or fast remedy for improving waits and that health care budgets are already strained, it only makes sense that those “holding the purse strings,” making the policy decisions, or providing care would be interested in deflecting the blame about long waits.

While some sources may intentionally try to steer the news media dialogue, one should also consider the aim of the journalist and the news media in all of this. The news “media has (sic) a tendency to discuss both sides of the story, they are not aiming to tell the truth; [instead,] they provide debate” (D. Clements, personal communication, December 10, 2006). The debate between levels of government and others over how to remedy waiting times is arguably one way of attaining the truth. In journalism, a successful story would reveal part of this truth in a way that is accessible and interesting to readers. To accomplish this in a story, the reporter would strive to give a clear and concise message (for example, the health care system needs more resources to reduce long waits) rather than telling all of the pieces (which, extending on the former example, might also involve collaboration, further research, etc.) at once. Consider Seale’s (2003) point that “[s]ome degree of simplification must be necessary if the dramatic oppositions that are the core device of story telling are to be created” (p. 514). Besides this, in journalism, these stories are not considered one-offs, but rather pieces of an ongoing narrative.

A final point on this theme is that the important detail about there being no quick fix or cure-all to reduce long waits was poorly communicated (or perhaps lost in the “more of everything” discussion) in the news articles in this study. Of course, citing this detail too much runs the risk of encouraging complacency on the part of decision or policy makers. Reversely, poor coverage of this detail runs the risk of pressuring decision or policy makers into hastily allocating resources (such as purchasing a new MRI or CT scanner), when, in fact, it may be best (for the system and the health of Canadians) to spend the money elsewhere.

The second major theme — the health care system is in crisis due to long waits — allows us to consider, once again, what we mean by “news.” The first criterion of a “good story” involves exposing failings (the “bad news”) in the way that power is exercised. The ability of

journalists to meet this criterion is fundamental to a free press and democracy. As it happens, “the democratic postulate is that the media are independent and committed to discovering and reporting the truth, and that they do not merely reflect the world as powerful groups wish it to be perceived” (Proffitt, 2007, p. 65). However, this watchdog principle — which Kovach and Rosenstiel (2001) refer to as the independent monitoring of power — is “often misunderstood, even by journalists, to mean ‘afflict the comfortable’” (p. 112). I think newspaper reporting of waiting times as shown in this study is a particularly good example of how the watchdog principle can go awry.

A read through of the news coverage on health care waiting times would have one believe Canada’s health care system is not just in need of a major overhaul, but beyond repair. The news coverage from this sample reveals that waiting times are growing “like a cancer,” creating “intolerable” suffering to patients, and are ailing due to crisis-level health human resource shortages and other irreconcilable system deficiencies.

I have already explored why the news media report on “bad news,” but there are other explanations to consider. For example, some might argue that the news media, which are businesses, report news as crisis to gain greater sales and readership. Of course, a distinction between the news media and journalists must be made here:

Journalists are driven by the same greed and vanity impulses as everyone else, but they do not concern themselves directly with selling newspapers. For the journalist to succeed, he/she needs to break important stories, or at least to get stories well placed. To do this, they have to meet the criteria of “the good story.” (M. Cobden, personal communication, February 22, 2007)

Others have argued that the news media sometimes have an entertainment agenda (Seale, 2003).

While it is true that the news media — in this case, newspapers — want readership, it is important to note that the news media, and journalists in particular, are largely unwilling to distort facts and risk a reputation for inaccuracy for the sake of an entertainment agenda (M. Cobden, personal communication, February 22, 2007).

The third and fourth themes — relating to the public/private health care debate and the debate over the most appropriate managed care techniques for improving waiting times — inspire further consideration into the role of journalists in telling both sides of a story. A debate on how health care is funded lends itself nicely to this kind of two-dimensional story. However, the news coverage in this sample tended to convey largely one side at a time — for example, stories that largely profiled the arguments for a public health care system versus those that profiled the arguments against. In addition, while some news articles confronted and debunked popular myths about a two-tier system, the overall news coverage in this sample failed to dispel these myths on a routine basis. In fact, the news coverage that supported private health care was arguably one of the drivers of these myths. Ultimately, there was also little in the way of “shades of grey” reporting; that is, there were few individual reports presenting an array of arguments from multiple perspectives. To get the multiple dimensions of an issue, the reader would ideally read her newspaper everyday — reading one side of the debate on Monday, and the other later in the week, which is in line with the journalism concept of the ongoing narrative.

The ongoing narrative is successful from the news media’s business standpoint, as it encourages readers to stay abreast of the latest news. From the reporter’s standpoint, this way of delivering the news is convenient, as it allows her to focus on one issue at a time, telling pieces of the larger story. In particular, this method follows the popular (albeit CBC mantra) that a news

story is about “somebody doing something for a reason” versus a number of persons doing (or saying) a number of things for various reasons.

What do the minor themes tell us?

Discussions of waiting times are often used as segues into other health care discussions. However, given the newsworthiness of health care waits, this is seemingly a clever ploy for increasing readership. At the same time, making reference to waiting times could be considered a case of “crying wolf,” which falsely keeps them on the public and political agendas, as is further explained in the next section on implications.

Discussions of waiting times are also sometimes framed in terms of values and principles such as accountability and comprehensiveness. In a system that is based on need, rather than ability to pay, it only makes sense that at least some of these discussions would be driven by values. However, it is interesting that these discussions were a minor theme, given the principles of the Canadian health care system and that most would argue Canada is a social welfare state. Much of the discussion of values originated with quoted sources — who, for example, call for accountability and transparency in each other’s actions. This ties in with the final minor theme regarding collaboration, whereby key players — again FPT government sources and physicians — call one another out on areas where improvement is needed, perhaps to deflect blame, as already discussed.

What do the under-represented topics tell us?

To this point, I have proposed possible explanations for news reporting that delivers simple messages, cries wolf, and focuses on the negative. But why do the news media fail to report certain topics altogether?

In this study, there was little coverage on the context of waits — for example, there was little context in terms of how different parties define waits and in terms of how timely access impacts on overall health care quality. In the same way, there was little contextual information provided around health care dollars — for example, in terms of what thousands of new health care dollars mean to a system that is already worth billions. In the pursuit of the truth, context is important to making sense of the facts:

Mere accuracy is also not what people are looking for. Journalist Jack Fuller, in his book, *News Values*, explains that there are two tests of truth according to philosophers: One is correspondence. The other is coherence. For journalism, these roughly translate into getting the facts straight and making sense of the facts. (Kovach & Rosenstiel, 2001, p. 43)

There are a few reasonable explanations for a lack of contextual information in news media reporting on waiting times. First, the nature of one- and two-dimensional reporting ultimately risks important messages and context being left out of the news altogether. In the same way, time and space constraints can also lead to under-reporting of context. Second, reporters may fail to ask their sources to clarify context, which may also be a result of time constraints or simply a lack of knowing the importance of certain contextual information. And third, those with a vested interest in or an expertise around waits may fail to offer important contextual information to the news media. As already discussed, some sources may wish to keep the public in the dark on health care waits (as their contribution of health care dollars may be more impressive to a public who has no concept of what the health care system is valued at). Other sources (such as researchers) may choose not to talk to the news media at all (for fear of being misrepresented, for example). And, still other sources (such as health care providers) may

have employment constraints (such as in-house regulations from communication specialists) prohibiting them from speaking directly with the news media.

A consideration of what is not reported is, in my mind, just as important to a news media representation as what is covered. Recall that for its own survival, journalism “must balance what readers know they want with what they cannot anticipate but need” and “strive to make the significant interesting and relevant” (CCJ, 2006a, ¶ 11). Context about how access impacts total quality of care, how waiting times are defined, and what health care dollars actually mean would seem to fall into the category of information the public needs but does not know it needs.

Implications

To this point, I have provided various hypotheses that attempt to make sense and provide reasonable explanations of my research findings. In this section, I aim to go one step further, providing insights on the theoretical (abstract) and practical (concrete) implications of my work. From a theoretical standpoint, for example, I share insights around the impact of my study findings on the role of the news media in shaping public understandings of waiting times. From a practical standpoint, I share insights into possible changes in journalism practices and how parties with a vested interest in or knowledge about waiting times communicate with the news media, as well as make suggestions for future directions in research initiatives.

Theoretical

Theoretical implications attempt to make sense of the world, ideas, images, narratives, or public discourses (D. Gustafson, personal communication, January 29, 2007). In this section, I make informed assertions about the role of the news media in shaping public understandings of waiting times as well as how the public makes sense of these news media representations. In

particular, I aim to respond to my third research objective, which involves making informed assertions about how news coverage of waiting times can influence the public's knowledge of health services and Canadian health policy regarding waiting times for medical services.

Implications of News Reporting on Behaviour, Practice, and Policy

The ability of the news media to play a public agenda-setting role is well-understood (Caburnay et al., 2003; Durrant et al., 2003; McCombs & Shaw, 1972) and recent research supports the idea that the public gets a fair share of its health and medical information from the news media (Entwistle, 1995; Johnson, 1998; Nelkin, 1996; Phillips et al., 1991).

However, the news media can sometimes miss important health and health care information (Caburnay et al., 2003; Stryker et al., 2005; Wilson et al., 2004; Wells et al., 2001; Shuchman & Wilkes, 2003). The danger in this is that without news media coverage, important topics can get left off the public and political agendas. For example, news media coverage of the health care system has largely focused on only two factors impacting the quality of health care: access to care and patient safety (Thornhill, Vigneault, & Clements, 2007). Meanwhile, other important factors (necessary to achieving a high-quality health care system) such as appropriateness, efficiency, efficacy, and patient-centredness (Institute of Medicine, 2001) fail to get any news media attention at all. This imbalance in news media coverage may falsely lead the public to believe some aspects of quality, such as patient-focused care initiatives like patient decision aids (see CHSRF, 2007), are unimportant. As a result, politicians may be complacent when it comes to making important investments in health and health care that fall outside of issues of access and safety. In fact, without a consideration of all of the dimensions of quality care, narrowly focused strategies can lead to a system that offers timely access to inappropriate, ineffective care, and ultimately poor-quality health care (Berwick, 2006).

The news media coverage of wait times in this study sample fails to reveal the growing body of research evidence, which finds wait times can actually benefit patients and the health care system at-large. In the final report by the federal advisor on wait times, Dr. Brian Postl acknowledges this point: “waiting before surgery may be appropriate in instances where a patient must improve his/her health status to ensure the success of a procedure or . . . to make personal arrangements either before or following surgery” (Postl, 2006, p. 64). In the factors Postl (2006) provides for consideration in his report, he argues that specific targeted initiatives – such as a proposed initiative Postl has aptly called “Why Comprehensive Wait lists are Good for your Health” – would be useful toward raising awareness among Canadians about the benefits of waiting lists. Unfortunately, this dialogue is absent from the news coverage in this study.

Another example of disproportionate news media coverage is the current focus on health care versus the broad concept of health (Hayes et al., in press) as it is defined by the WHO (1986), among others. Although it was never my intention to address issues of health promotion (as I intentionally retrieved stories about waiting times for health services), there is an important question to be asked: with all of the news media coverage on waiting times and health care, what does that say about how reporters, the news media, and, in fact, newsmakers, perceive health? In my mind, there is a narrow vision of health and there remains a poor understanding of the social determinants of health at large.

Framing (or what problems and solutions are portrayed by the news media as being important, newsworthy, or befitting the “good story”) has further implications for health care policy- and decision-making. In this study — as in Collins et al. (2006) — the proposed solutions were too general to lead to any real changes. For example, at a time when health care budgets are already tight, “more of everything” is not a reasonable answer to the problem of reducing waits.

This kind of solution is also not particularly helpful given what we know about how increasing access to health care can actually lead to greater waits (Flood, 2006) and reduced health care quality (Berwick, 2006). A more accurate discussion of solutions might sometimes indicate there are no quick fixes or cure-alls when it comes to improving waits. Without this disclaimer, the public may develop false perceptions about what it takes to reduce waits. In turn, the public may place unwarranted pressure on health care policy and decision makers, as well as providers, to reduce waits sooner than is feasible. Ultimately, such pressure may keep governments and other key players from making more “upstream” investments in health care — investments that aim for practical, long-term health care benefits versus unrealistic, short-term ones.

News media coverage of health service waits also begs the question is the news media giving an accurate picture of health care waiting times? This study supports the hypothesis that the news media have a tendency to report negative information and construct crisis when it comes to news coverage of waiting times for health services. In the end, this reporting insufficiently informs the public about health care waits (particularly progress to reduce waits) and the overall quality of the Canadian health care system. However, from a journalism perspective, uncovering exceptions to timely access to care is not only legitimate, but responsible.

To be fair, it is important to note that while the public may be influenced by the news media, it is also influenced by other factors (including other people). And this study does not show that the public has been misinformed (or impacted at all, for that matter) by news media reporting of health care waiting times. Furthermore, there is significant value in news media coverage of waiting times for health services, as this coverage encourages debate and ultimately holds those who make decisions about health care (particularly waiting times) responsible for

their actions. Of course, this impact would be better appreciated (by researchers, system managers, and providers) if it profiled a broad picture of the state of waiting times in Canada's health care system.

Implications of News Reporting on Health Literacy

Most health communication is intended "to inform the public about health concerns and to maintain important health issues on the public agenda" (WHO, 1998, p. 8). In this way, the news media may act as resources from which individuals may seek and draw health and health care information. However, much of the information that arises from news media coverage is far too general to lead to any real changes, as was demonstrated in my discussion of the news media's focus on simple, quick fixes for remedying long health care waits.

For Atlantic Canadians (who have among the lowest literacy levels in Canada), coverage that accentuates the negative, cries wolf, and under-reports certain issues can especially impact negatively on health literacy. In fact (and as I have already discussed), such reporting can create false beliefs about the stability of the health care system, which may lead to the public putting misguided pressure on those who make policy and practice decisions. Such misdirected pressure serves only to hurt the health care system (and, ironically, the public), as it may force policy makers to focus their health care improvement efforts too narrowly on issues of access.

If the public is to understand and use news media messages, these must be clearly communicated (Rudd, Comings, & Hyde, 2003). Such "[c]lear communication is . . . needed to dispel myths, to reduce fears, and, in times of crisis, to alert the public and provide directions for urgent action" (Rudd et al., p. 104). As risk communication literature tells us, "[m]ass media agendas and health communication objectives can be authoritative allies or forceful foes when it comes to supplying the public with accurate and timely health information" (Payne & Schulte,

2003, p. 124). When health information is clearly communicated, unnecessary panic can be avoided (Payne & Schulte, 2003).

But ultimately how do we improve news coverage of health care waits? As I explain in the next section, improvement will involve changes from the inside in terms of how journalism is practiced and produced, but also changes from the outside in terms of how parties with a vested interest or expertise in health care waits communicate their messages to the news media.

Practical

From a theoretical standpoint, I have discussed the implications of news reporting of health care waiting times on behaviour, practice, policy, and health literacy. In this section, I explore practical changes in journalism practices and how those with a vested interest in or knowledge about waiting times communicate with the news media. In addition, I make suggestions for future research.

Possible Changes from Inside the News Media

Those who communicate health information have some important questions to consider: “What information must people understand to be able to take care of their health? [And, h]ow do we make sure that information is adequately communicated so that everyone who needs it can access and understand it?” (Parker & Gazmararian, 2003, p. 116). McCray (2005) says “[p]erhaps one of the most significant challenges we face is to make health information accessible to everyone, regardless of background, education, or literacy level” (p. 152). All of this is not to say that newspaper journalists ought to ensure their news sufficiently meets a grade-six reading level (or some other standard for materials distributed to the lay public). Instead, news media producers and advertisers must anticipate and meet the needs and wants of their target audiences. Of course, as a discussion of health literacy has revealed, even the most

educated persons are not immune to having inadequate knowledge and understanding of health and health care information (Gillis, 2005).

One popular suggestion for reporters is it to tell as much of the whole story as possible, which includes “identification of a problem, link[ing] a proposed behaviour or strategy as a way of addressing the problem and suggest[ing known activities that] . . . lead to a desired outcome somewhere down the road” (Clements, 2006, p. 8). Moreover, when communicating health information (particularly public health information) “a clear focus, a credible source of information, an acknowledgment of what is known and what is not yet known, clear and consistent directions for action, and a friendly and inclusive tone will serve the nation well” (Rudd et al., 2003, p. 112).

Reporters are also encouraged to share important nuances and caveats such as conflicts of interest in their stories (Cassels et al., 2003a, 2003b; Cope, 2003; Schwartz and Woloshin, 2004) or, in this case, important contextual information around how waits are defined, measured, and managed. Finally, the CCJ and various journalists (2006b) have prepared a short list of ways journalists can “make the political meaningful” (§ 1). According to their work, “[c]itizens frequently complain that political coverage is boring and seems to have no bearing on their lives” (CCJ, 2006b, § 1). This guide offers suggestions for storytelling in journalism, including asking reporters to “do more stories about how a decision got made” (CCJ, 2006b, § 5) and “stop doing things to please yourself, your sources or your peers” (§ 6).

Possible Changes from Outside the News Media

Facilitating the public’s understanding of health-related information should not fall solely on the shoulders of journalists. For example, journalists may make great strides to ensure they have effectively communicated a health care issue, but if the story contains misinformation those

strides may be of little overall value. Instead, governments, researchers, and health care providers must intervene to provide the public and patients (respectively) with the skills necessary to apply specific health information to their own lives (Payne & Schulte, 2003). In fact, a frequently suggested strategy for improving health news is for researchers and health care providers to assist and work with journalists in ensuring the accuracy of health and medical news reporting (Nelkin, 1996; Schraeder, 2003; Schwartz & Woloshin, 2004; Shuchman & Wilkes, 1997; Waddell et al., 2005).

One particular strategy that has been suggested for making journalism less sensational and more evidence-based is to teach journalists critical appraisal skills (Larsson et al., 2003; Moynihan, 2003; Schwartz & Woloshin, 2004). Fortunately, initiatives such as “Media Doctor” in Australia and Canada and the “Hitting the Headlines” project in the U.K. now conduct regular audits of medical news to improve the quality of health news reporting (Media Doctor Australia, 2006; Media Doctor Canada, 2006; National electronic Library for Health, 2005; Smith, Wilson, & Henry, 2005). In addition, medical journalists, researchers, and others have created tools (for example, the checklist for covering the release of a new prescription drug by Cassels et al., 2003b) to assist reporters who cover health news. As I will explain in my conclusion, further research and development may serve the news media and the public well.

Limitations

In terms of limitations, there are several shortcomings to the study methodology:

- I examined only daily newspapers and therefore have no data to show if differences exist between newspapers and other print media. Similarly, this study is unable to make inferences as to the reporting on waiting times for medical services in such broadcast media as radio, television, and the Internet. Although I cannot make specific

suppositions, daily newspapers are thought to generally set the agenda for broadcast news coverage (M. Cobden, personal communication, October 2005). Research that incorporates a sample across news media would, however, give a broader understanding of news media coverage of waiting times for medical services.

- This study involved a sample of reporting from four specific Atlantic Canada daily newspapers over a longitudinal period of time. This sample may or may not be representative of broader trends in Canadian newspaper reporting on waiting times for medical services.
- Since I retrieved text-only versions of the newspaper documents, I was unable to analyse important visual aspects of newspaper coverage, including where the news story was positioned on a given page; what font size was used for the headline; and how much of the story text was located on a given page. This information is particularly useful for assessing story prominence. However, I was able to cross-tabulate other variables to measure story prominence. If I were to do this kind of study again, I would want to consider story prominence more closely. Also, I should note that while the story prominence variable in this study is interesting, it may be considered an artificial calculation such that it offers only an indication rather than an accurate picture of story prominence.
- The inclusion criteria for this study limits data collection to newspaper documents containing specified search terms in the headline and lead (first two paragraphs). Gazso (2004) points out that one of the weaknesses of a media analysis that makes use of search terms is that the search criteria ultimately limit the sample. Although I began my study with a finite number of search terms, I allowed other search terms to emerge, which

enabled me to expand my sample size. Another weakness that arises from my inclusion criteria is that this search strategy may exclude newspaper documents about waiting times for medical services that have anecdotal or “delayed” leads. In newspaper documents with anecdotal leads, which are common in feature stories and increasingly common even in news stories, it is often not until the fifth or sixth paragraph that the reporter gets to the nut-graph or “the nut or kernel of the story” (M. Cobden, personal communication, October, 2005). A study that included these kinds of newspaper documents would provide a more accurate view of newspaper portrayal of waiting times for medical services.

- This study aims to make informed assertions about the influence of newspaper coverage of waiting times for medical services on the public’s knowledge of health services in Canada. Seale (2003) points out that making these kinds of assertions ignores true audience experience. In a typical media analysis, a single topic is selected as the analysis focus, with data collection aiming to gather data about the way the media represent this topic. In a real setting, argues Seale (2003), it is unlikely that one individual would read newspaper coverage on a single topic so thoroughly. Instead, the audience experience is more fragmented (Seale, 2003).
- This study also aimed to explore and describe news coverage of waiting times for medical services against a backdrop of key Canadian policy and research developments. While I make attempts to examine, confirm, and dispute the accuracy of some of the claims regarding waiting times for medical services in Canada, further analysis of the factual nature of these claims would provide additional insight into the quality of newspaper reporting about waiting times for medical services.

Conclusions

The purpose of this news media representation study was to explore and describe a sample of Atlantic Canada daily newspaper coverage of wait times for medical services and to make informed assertions about how this coverage can influence the public's knowledge of health services and Canadian health policy. According to this study, when the news media report on wait times for health services, this coverage tends to capture the thoughts and ideas of mainly a select group of sources, include mainly negative information and, in some cases, construct crisis. There are a number of possible implications such reporting can lead to including: sending a false message that only some select groups are "experts" about wait times; generating false public beliefs (and even fears) about the stability of the Canadian health care system; and leading to misguided health policy and practice decisions around wait times. Most troublesome is that a narrow focus on improving access ignores other factors that are necessary for building a high-quality Canadian health care system.

But how might we work to improve health care news coverage? Journalists want their stories to be readable, which means they must write in a conversational, narrative, concrete, and clear (versus an expository, bureaucratic, academic, and abstract) way. Good stories – from a journalism perspective – must ultimately be written about people, particularly individual people, who take on the role of characters in the story. Further to this, "the good story" will present news that marks an exception to the rule and is outside the norm, but is also relevant for audiences. For news coverage about access to care, this means that stories of patients who wait beyond wait time benchmarks will be presented. This is, in fact, the role of the news media and, more precisely, journalists, to be asking questions when and where it is perceived that access to health care services is compromised, for example.

In the end, facilitating the public's understanding of health-related information is not the sole responsibility of journalists. Instead, governments, researchers, and health care providers must intervene to provide the public and patients (respectively) with the skills necessary to apply specific health information to their own lives. Of course, a greater understanding from journalists about the implications of poor news reporting and from governments, researchers and providers about the concept of "the good story" may encourage collaboration from all parties. I turn now to a consideration of future research.

Future Directions in Research Initiatives

As this study was the first of its kind (that I know of) to specifically explore how the news media represent waiting times for medical services, further research to fill in the gaps in our understanding of this question may be called for. In particular, further research into whether news coverage of waiting times from other news media (for example, national newspapers or broadcast news media) would produce findings that are consistent with this work may be helpful. In the same way, it may be helpful to explore coverage within a more narrow frame (for example, coverage of the Chaoulli decision; coverage of the public/private health care debate; or coverage of the national benchmarks), as one may be better able to draw specific conclusions around the accuracy of news media coverage. Perhaps most importantly, surveying the public to assess the effects of types of news reporting on perceptions would also create new knowledge in this area.

In addition to future research around our gaps in understanding of how the news media portray health care, there are also possible research initiatives that could focus on remedial action to solve the problem of poor news coverage. For example, greater research into the quality of

news coverage offered by health reporters versus staff or other reporters may be helpful. In the same way, research and development of useful tools for journalists who report on health and health care, including tools that aim to teach critical appraisal skills to journalists, would also be beneficial.

ACKNOWLEDGEMENTS

First and foremost, I would like to thank my supervisor, Diana Gustafson, for her ongoing and never failing mentorship and support (intellectual and otherwise). I would also like to acknowledge and thank the rest of my supervisory committee (whom, along with Diana, I affectionately refer to as the “dream team”): Natalie Beausoleil, Michael Cobden, and Andria Jones. I must recognize the technical and financial support and, of course, the intellectual support from my professors and colleagues of the Atlantic Regional Training Centre. Finally, I would like to thank every one who took the time to offer advice, assistance, or simply a listening ear: most notably, the “fab five” from MUN (you know who you are), Cynthia Cheponis, Dave Clements, Pat Conrad, Cathy Peyton, Chrissy Skinner, Raman Verma, and my cat, Evan (surely he should be graduating too).

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Appendix A: Waiting Times in Canada — Timeline of Key Events

Table 20

Timeline of key events around waiting times in Canada

Date	Event
1988 (to present)	<p><u>The Fraser Institute’s first national waiting list survey</u> — Since 1988, the Fraser Institute — an independent public policy organization established in 1974 — has published an annual survey reporting physicians’ estimates of hospital waiting times across Canada. This survey collects data from each province on surgical waiting times for 12 different specialties (plastic surgery, gynecology, urology, ophthalmology, otolaryngology, general surgery, neurosurgery, orthopedics, cardiology, urology, and internal medicine). Although the first of these annual surveys was limited to physicians in British Columbia, and the second was limited to physicians in British Columbia, Manitoba, Newfoundland and Labrador, New Brunswick, and Nova Scotia, the remainder have involved physicians from all Canadian provinces. The most recent Fraser report, “Waiting Your Turn: Hospital Waiting Lists in Canada” was released in October 2006 (Esmail & Walker, 2006).</p>
June 1998	<p><u>McDonald et al. release report on waiting lists and waiting times in Canada</u> — In a six-month project funded by Health Canada, McDonald et al. sought to provide “a comprehensive critical review and synthesis of published and unpublished literature on the nature, extent, and factors influencing wait lists and wait times,” “an assessment of current provincial/territorial activities related to the management of wait lists and wait times,” and “an assessment of the current state of wait lists and wait times” for a subset of clinical conditions in Canada (McDonald et al., 1998, p. ii-iii). This project, “Waiting lists and wait times for health care in Canada: More management!! More money??” comprised a number of initiatives, including an appraisal of the literature, surveys of hospitals and regional health authorities, interviews with consumers, and more. In the end, the authors reported “one of the disturbing findings . . . is how little is known about the extent, nature, or determinants of wait lists and wait times in [Canada]” (McDonald et al., 1998, p. iii).</p>
1999	<p><u>Western Canada Waiting List Project (WCWL)</u> — Funded through Health Canada’s \$2.1M Health Transition Fund, the WCWL — a partnership of medical associations, ministries of health, regional health authorities, and health research centres — was developed with “a mission to improve the fairness of the health care system so that Canadians’ access to appropriate and effective medical services is prioritized on the basis of need and potential to benefit” (WCWL, 2003). The WCWL “sought to develop physician-scored, valid, reliable, practical, and clinically transparent measures of patients’ priority for selected wait-listed services” (WCWL,</p>

	<p>2003). The first phase of WCWL — which began in 1999 and ended in 2001 — saw the development of waiting list management tools in five clinical areas (children’s mental health, cataract surgery, general surgery, hip/knee replacement surgery, and MRI scanning) (WCWL, 2003). With funding from Health Canada and the four western Canadian provinces, the second phase of work began in April 2002. The objectives of the second phase included implementation and evaluation of the waiting list management tools; development of standardized maximum acceptable waiting times linked to WCWL tool scores; and adaptation of the WCWL tools for use by primary care providers.</p>
2000	<p><u>The Canadian Institute for Health Information (CIHI) releases waiting times information in “Health Care in Canada” reports</u> — CIHI has released waiting times data in their annual report, “Health Care in Canada,” since 2000 (CIHI, 2006b).</p>
September 11, 2000	<p><u>First Ministers’ Communiqué on Health</u> — As part of their action plan for health system renewal, provincial and territorial governments agreed to work to improve the timely access to health services of highest priority to Canadians. In an effort to demonstrate “clear accountability,” First Ministers also agreed to direct health ministers to regularly and publicly report on comparable health performance indicators beginning in September 2002. These indicators would address — in addition to the themes “health status” and “health outcomes” — “quality of service,” which includes waiting times for key diagnostic and treatment procedures (Canadian Intergovernmental Conference Secretariat, 2000).</p>
2001	<p><u>Statistics Canada releases its first access to care report</u> — As a supplement to the “Canadian Community Health Survey,” Statistics Canada’s “Access to Health Care Services in Canada” (Statistics Canada, 2001; 2003b) was “specifically designed to improve our understanding of patients’ experiences accessing health care services, notably waiting times” (Health Canada, 2006). This report (and the follow-up, which was released in 2003) “provide detailed survey findings on access to family physicians, 24/7 access to first contact services, self-reported unmet health needs, non-urgent access to specialized services (for example, specialist visits for new illnesses/conditions, non-emergency surgery, and selected diagnostic tests), and waiting for care” (Health Canada, 2006).</p>
March 31, 2001	<p><u>Western Canada Waiting List (WCWL) project releases its final report from phase one</u> — The WCWL released its report, “From Chaos to Order: Making Sense of Waiting Lists in Canada” in March 2001. In addition to laying out the context and relevance of waiting times in Canadian health care, this report provided five tools for rating case urgency using “Priority Criteria Scores.” These tools are intended to assist in waiting list management for selected diagnostic, procedural, and consultative procedures (WCWL, 2001).</p>
October 2002	<p><u>The Standing Senate Committee on Social Affairs, Science and Technology tables its final report</u> — In this final report (chaired by the Honourable Michael J.L. Kirby), “The Health of Canadians — the Federal</p>

Role,” the committee recommended “For each type of major procedure or treatment, a maximum needs-based waiting time be established and made public” and “When this maximum time is reached, the insurer (government) pay for the patient to seek the procedure or treatment immediately in another jurisdiction, including, if necessary, another country (e.g., the US)” (The Standing Senate Committee on Social Affairs, Science and Technology, 2002, p. 117). The committee called this second recommendation the “Health Care Guarantee.” According to the report, “the point at which this health care guarantee would apply for each procedure would be based on an assessment of when a patient’s health or quality of life is at risk of deteriorating significantly as a result of further waiting” (The Standing Senate Committee on Social Affairs, Science and Technology, 2002, p. 118). To establish clinical, evidence-based criteria to establish waiting times, the committee recommended “The process to establish standard definitions for waiting times be national in scope;” “An independent body be created to consider the relevant scientific and clinical evidence;” and “Standard definitions focus on four key waiting periods — waiting time for primary healthcare consultation; waiting time for initial specialist consultation; waiting time for diagnostic tests; waiting time for surgery” (The Standing Senate Committee on Social Affairs, Science and Technology, 2002, p. 118).

November 28,
2002

Commission on the Future of Health Care in Canada tables its final report — In this final report (led by Commissioner Roy J. Romanow), “Building on Values: The Future of Health Care in Canada,” Romanow makes two recommendations for reducing waiting times and managing waiting lists: “Recommendation 25: Provincial and territorial governments should use the new Diagnostic Services Fund to improve access to medically necessary diagnostic services;” and “Recommendation 26: Provincial and territorial governments should take immediate action to manage wait-lists more effectively by implementing centralized approaches, setting standardized criteria, and providing clear information to patients on how long they can expect to wait” (Romanow, 2002, p. 138).

February 5, 2003

First Ministers’ Accord on Health Care Renewal — One of the objectives of the Health Accord was to ensure that Canadians have round-the-clock (“24 hours a day, 7 days a week”) access to a health care provider as well as timely access to diagnostic procedures and treatments. First Ministers agreed to continue regularly and publicly reporting health indicators, expanding the reporting themes — “quality,” “sustainability,” and “health status and wellness” — to include the theme of “timely access” (Health Canada, 2003). This theme incorporated indicators relating to waiting times and access to health care providers and services. Participating provinces and territories also agreed to release their second performance indicators report in November 2004. Finally, First Ministers established a national, non-profit health council — the Health Council of Canada — to monitor and make annual public reports on the implementation of the accord (as well as the upcoming 10-Year Plan to Strengthen Health Care), with

	particular attention to accountability and transparency provisions (Health Canada, 2003).
May 2004	<u>The Taming of the Queue: Wait Time Measurement, Monitoring and Management report is released</u> — This report by then-director of the Canadian Policy Research Network’s (CPRN) Health Network, Cathy Fooks, summarized the information and key messages from the discussions of the colloquia by the same name. The report concludes with a summary of best practice proposals (Fooks, 2004).
September 16, 2004	<u>First Ministers’ Meeting on the Future of Health Care (10-year plan)</u> — During this meeting, First Ministers agreed that access to timely care across Canada is a national priority, requiring a shared agenda; that is, “ensuring that Canadians have access to care they need, when they need it” (Canadian Intergovernmental Conference Secretariat, 2004a; Health Canada, 2004). First Ministers committed to the following two objectives: better waiting times management; and measurable waiting times reduction where these waiting times are longer than medically acceptable. Building on the work within each jurisdiction to address waiting times, First Ministers committed to achieving “meaningful reductions in wait times in priority areas such as cancer, heart, diagnostic imaging, joint replacements, and sight restoration by March 31, 2007, recognizing the different starting points, priorities, and strategies across jurisdictions” (Canadian Intergovernmental Conference Secretariat, 2004a; Health Canada, 2004). As part of their commitment, First Ministers agreed to collect and report information on the progress made in reducing waiting times as follows: <ul style="list-style-type: none"> • each jurisdiction to establish comparable indicators of access to health care professionals, diagnostic, and treatment procedures with a report to their citizens to be developed by all jurisdictions by December 31, 2005; • evidence-based benchmarks for medically acceptable waiting times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration to be established by December 31, 2005 through a process to be developed by federal, provincial, and territorial ministers of health; • multi-year targets to achieve priority benchmarks to be established by each jurisdiction by December 31, 2007; and • provinces and territories to report annually to their citizens on their progress in meeting their multi-year waiting time targets. In addition, the Canadian Institute for Health Information agreed to report on the progress made in reducing waiting times across jurisdictions. As described in the agreement “Asymmetrical federalism that respects Québec’s jurisdiction,” which accompanied the 10-Year Plan, Québec decided to apply its own waiting time reduction plan in accordance with the objectives, standards, and criteria established by the relevant Québec authorities (Canadian Intergovernmental Conference Secretariat, 2004b).
2004	<u>Health Council of Canada (HCC) is given an enhanced monitoring role</u> — In addition to monitoring the provisions of the 2003 Accord on Health Care

	Renewal, Canada's First Ministers gave the HCC the role of monitoring the provisions in the 2004 10-Year Plan to Strengthen Health Care.
2004	<u>Wait Times Reduction Fund is available</u> — The federal government made the Wait Times Reduction Fund available to augment existing provincial and territorial investments and initiatives to reduce waiting times. In particular, the federal government committed \$5.5 billion in this 10-year fund (HCC, 2006); established a six-year \$4.5 billion fund. The fund was introduced to be used for “jurisdictional priorities such as training and hiring more health professionals, clearing backlogs, building capacity for regional centres of excellence, expanding appropriate ambulatory and community care programs and/or tools to manage wait times” (Health Canada, 2006).
2004	<u>Wait Time Alliance (WTA)</u> — The WTA was created in the fall of 2004 as a physician alliance, which comprised several national medical specialty societies, whose members are involved in providing care in the five priority areas — cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration (WTA, 2005b).
February 28, 2005	<u>Western Canada Waiting List Project (WCWL) releases its final report</u> — In its final report, “Moving Forward,” WCWL provided an overview of its work-to-date (including its role and accomplishments), as well as further insights into tools for managing waiting times in such areas as hips and knee replacements and mental health (WCWL, 2005). Most importantly, this report included a set of maximum acceptable waiting times.
April 2005	<u>Wait Time Alliance (WTA) releases its interim report</u> — The WTA released its interim report, “No More Time to Wait: Toward Benchmarks and Best Practices in Wait Time Management,” in March 2005 (WTA, 2005b). This physician-perspective report was reportedly the first to present a set of provisional medically acceptable waiting time benchmarks or performance goals in the five priority areas (Eggertson, 2005). The WTA released its second report, “It’s about time. Achieving benchmarks and best practices in wait time management” in August 2005 (WTA, 2005a).
June 9, 2005	<u>Supreme Court of Canada rules on Chaoulli/Zelotis case</u> — Waiting times for medical services continued to dominate the public discourse in 2005. In fact, the Supreme Court of Canada’s historic decision in the Chaoulli/Zelotis case (Supreme Court of Canada, 2005) underscored the importance of reducing waiting times for publicly funded health services. The decision overturned a lower court ruling preventing Québeckers from buying private health care insurance. Many saw this decision as a stark reminder that long waiting times in the public health care system can endanger people’s lives.
July 2005	<u>Federal Advisor on Wait Times is appointed</u> — Dr. Brian Postl was appointed in July 2005 to facilitate progress on waiting time commitments made by First Ministers in September 2004.
July 2005	<u>The Taming of the Queue II report is released</u> — This report, by the director of the CPRN’s Health Network, Tom McIntosh, provided a

	<p>province-by-province overview of recent developments in waiting time management, as well as summaries of conference presentations by experts from Canada and abroad (McIntosh, 2005). The report, as per the last one, is the result of a colloquia by the same name (McIntosh, 2005).</p>
November 2005	<p><u>Health Council of Canada (HCC) releases its report</u> — The HCC released “10 Steps to a Common Framework for Reporting on Wait Times” in November 2005. As the name suggests, the plan incorporated 10 steps, which included such areas as reporting on waiting times, determining priorities (for who gets access to care first), monitoring progress, and balancing capacity and demand (HCC, 2005).</p>
November – December 2005	<p><u>Some provinces announce they are unable to meet December 2005 milestone</u> — A number of provinces announced they would be unable to meet their deadlines for setting benchmarks for waiting times in the priority areas (McIntosh, 2006). In particular, only Nova Scotia, Ontario, and Alberta produced waiting times data in all five priority areas (cancer, heart, diagnostic imaging, joint replacement, and sight restoration). Meanwhile, Manitoba and British Columbia provided waiting times data in four areas; Saskatchewan and Québec in three; Prince Edward Island in two; and Newfoundland and New Brunswick in one.</p>
November 16, 2005	<p><u>Canadian Institutes of Health Research (CIHR) releases research results to inform the development of benchmarks for waiting times</u> — CIHR’s Institute of Health Services and Policy Research (IHSPR) released eight research syntheses from its “Toward Canadian Benchmarks for Health Services Wait Times: Evidence, Application and Research Priorities” request for applications (CIHR, 2005a). These syntheses cover waiting times in the areas of cancer, joint replacement, and sight restoration (CIHR, 2005a). These reports helped create the first-ever national benchmarks for waiting times and were intended to inform the First Ministers’ deliberations prior to their December 2005 milestone for establishing national benchmarks (Barer, 2006; CIHR 2005b). In December 2005, IHSPR launched a second waiting times benchmark request for applications for the areas of cardiac procedures, diagnostic imaging, cancer treatments, and conditions not addressed by the four cancer research teams initially funded (Barer, 2006).</p>
December 12, 2005	<p><u>First common Canadian benchmarks to measure progress in reducing waiting times are reached</u> — According to the benchmarks — which are based on research and clinical evidence — provinces and territories propose to provide radiation therapy to treat cancer within four weeks of patients being ready to treat; hip fracture fixation within 48 hours; hip replacements within 26 weeks; knee replacements within 26 weeks; surgery to remove cataracts within 16 weeks for patients who are at high risk for complications (for example, blindness) from cataracts; breast cancer screening for women aged 50 to 69 every two years; and cervical cancer screening for women aged 18 to 69 every three years after two normal tests (Ministry of Health and Long-Term Care, 2005). For cardiac bypass surgery, three benchmarks were established (reflecting how</p>

	urgently care is required for some patients): Level I patients are seen within two weeks; Level II patients within six weeks; and Level III patients within 26 weeks. These benchmarks do not apply to emergency procedures; rather, patients requiring emergency care are to continue to be seen as soon as possible (Ministry of Health and Long-Term Care, 2005).
2005-2006	<u>Canadian Institute for Health Information (CIHI) convenes the Wait Times Measurement Symposium</u> — this symposium was a venue for sharing progress to date and identified challenges for effective waiting times measurement.
December 2005 – January 2006	<u>Liberals and Conservatives make “care guarantees” a key election plank</u> — During the federal election, both the Liberals and Conservatives made “care guarantees” a key election platform plank (McIntosh, 2006).
February 2006	<u>The Health Council of Canada (HCC) releases its annual report to Canadians</u> — In its “Annual Report to Canadians 2005,” the HCC provides an overview of what governments promised versus where we are now in terms of reducing waiting times in Canada (HCC, 2006). The report specifies three things that still need to be done: improving public information on waiting times; developing a package of reforms to reduce waiting times; and focusing on appropriateness of care and health outcomes (HCC, 2006).
2006	<u>Canadian Institute for Health Information (CIHI) releases its progress report</u> — The report, “Waiting for Health Care in Canada: What We Know and What We Don’t Know,” revealed there is better information on waiting times than ever before, but it also indicated that “we still do not have a comprehensive, cross-Canada picture on waits” (Barer et al., 2006, p. 28). A <i>Canadian Medical Association Journal</i> article summarized the patchwork nature of information on waiting times in Canada in its title, “Apples, oranges and wait times: CIHI report” (Kondro, 2006). Among the factors the report addressed as affecting Canadians’ waits for health care services include what procedure a patient is waiting for; whose list a patient is on; how urgently a patient needs care; and other special factors related to patients or their conditions (CIHI, 2006a). The report also provided an overview of the patchwork information that exists on waiting times across Canada, providing details on what we know and do not know across the spectrum of health care (CIHI, 2006a).
June 30, 2006	<u>Federal wait times advisor releases his final report</u> — The federal wait times advisor, Dr. Brian Postl, released his final report, which reflects the work and the consultations he conducted with governments, health care professionals, and other experts (Postl, 2006).

Appendix B: Federal and Provincial Waiting Time Initiatives

Table 21

Canadian federal and provincial waiting time initiatives and web sites

Initiative	Web Site
Newfoundland's <i>HealthScope</i> 2004	http://www.health.gov.nl.ca/health/publications/pdffiles/healthscope_report_2004.pdf
Prince Edward Island's <i>Second Report on Common Health Indicators</i>	www.gov.pe.ca/photos/original/hss_2nd_r_chi.pdf
Nova Scotia Wait Times web site	www.gov.ns.ca/health (click on Wait Times) (or http://www.gov.ns.ca/health/waittimes/)
New Brunswick's <i>Health Performance Indicators</i>	www.gnb.ca/0391/pdf/healthperformanceindicators2004-e.pdf
Québec's Surgery and Treatment Waiting Lists web site	http://wpp01.msss.gouv.qc.ca/appl/g74web/ www.msss.gouv.qc.ca/en/sujets/organisation/waiting_lists.html
Ontario's Cancer Care Wait Times web site	www.ccn.on.ca (click on waiting lists question) (or http://www.cancercare.on.ca/index_statisticsandresearch.htm)
Ontario's Cardiac Care Network web site	http://www.ccn.on.ca/
Ontario's Wait Time Strategy web site	http://www.health.gov.on.ca/transformation/wait_times/wait_mn.html
Manitoba Health Services Wait Time Information web site	http://www.gov.mb.ca/health/waitlist/index.html www.gov.mb.ca/health/pirc/index.htm
Saskatchewan Surgical Care	www.sasksurgery.ca (click on Wait Time Information) (or http://www.sasksurgery.ca/)

Network web site	
Alberta Wait List Registry web site	www.health.gov.ab.ca (click on Initiatives and then Wait List Registry) http://www.ahw.gov.ab.ca/waitlist/WaitListPublicHome.jsp
British Columbia Surgical Wait List Registry web site	www.healthservices.gov.bc.ca (click on Surgical Wait Times) (or http://www.healthservices.gov.bc.ca/waitlist/index.html)

Appendix C: The Elements of Journalism

The nine core principles of journalism [as defined by Kovach and Rosenstiel (2001), but cited in CCJ (2006) are:

1. “Journalism’s first obligation is to the truth
Democracy depends on citizens having reliable, accurate facts put in a meaningful context. Journalism does not pursue truth in an absolute or philosophical sense, but it can — and must — pursue it in a practical sense. This ‘journalistic truth’ is a process that begins with the professional discipline of assembling and verifying facts. Then journalists try to convey a fair and reliable account of their meaning, valid for now, subject to further investigation. Journalists should be as transparent as possible about sources and methods so audiences can make their own assessment of the information. Even in a world of expanding voices, accuracy is the foundation upon which everything else is built — context, interpretation, comment, criticism, analysis and debate. The truth, over time, emerges from this forum. As citizens encounter an ever greater flow of data, they have more need — not less — for identifiable sources dedicated to verifying that information and putting it in context. (§5)
2. “Its first loyalty is to citizens
While news organizations answer to many constituencies, including advertisers and shareholders, the journalists in those organizations must maintain allegiance to citizens and the larger public interest above any other if they are to provide the news without fear or favor. This commitment to citizens first is the basis of a news organization’s credibility, the implied covenant that tells the audience the coverage is not slanted for friends or advertisers. Commitment to citizens also means journalism should present a representative picture of all constituent groups in society. Ignoring certain citizens has the effect of disenfranchising them. The theory underlying the modern news industry has been the belief that credibility builds a broad and loyal audience, and that economic success follows in turn. In that regard, the business people in a news organization also must nurture — not exploit — their allegiance to the audience ahead of other considerations. (§6)
3. “Its essence is a discipline of verification
Journalists rely on a professional discipline for verifying information. When the concept of objectivity originally evolved, it did not imply that journalists are free of bias. It called, rather, for a consistent method of testing information — a transparent approach to evidence — precisely so that personal and cultural biases would not undermine the accuracy of their work. The method is objective, not the journalist. Seeking out multiple witnesses, disclosing as much as possible about sources, or asking various sides for comment, all signal such standards. This discipline of verification is what separates journalism from other modes of communication, such as propaganda, fiction or entertainment. But the need for professional method is not always fully recognized or refined. While journalism has developed various techniques for determining facts, for

instance, it has done less to develop a system for testing the reliability of journalistic interpretation. (§ 7)

4. “Its practitioners must maintain an independence from those they cover
Independence is an underlying requirement of journalism, a cornerstone of its reliability. Independence of spirit and mind, rather than neutrality, is the principle journalists must keep in focus. While editorialists and commentators are not neutral, the source of their credibility is still their accuracy, intellectual fairness and ability to inform — not their devotion to a certain group or outcome. In our independence, however, we must avoid any tendency to stray into arrogance, elitism, isolation or nihilism. (§ 8)
5. “It must serve as an independent monitor of power
Journalism has an unusual capacity to serve as watchdog over those whose power and position most affect citizens. The Founders recognized this to be a rampart against despotism when they ensured an independent press; courts have affirmed it; citizens rely on it. As journalists, we have an obligation to protect this watchdog freedom by not demeaning it in frivolous use or exploiting it for commercial gain. (§ 9)
6. “It must provide a forum for public criticism and compromise
The news media are the common carriers of public discussion, and this responsibility forms a basis for our special privileges. This discussion serves society best when it is informed by facts rather than prejudice and supposition. It also should strive to fairly represent the varied viewpoints and interests in society, and to place them in context rather than highlight only the conflicting fringes of debate. Accuracy and truthfulness require that as framers of the public discussion we not neglect the points of common ground where problem solving occurs. (§ 10)
7. “It must strive to make the significant interesting and relevant
Journalism is storytelling with a purpose. It should do more than gather an audience or catalogue the important. For its own survival, it must balance what readers know they want with what they cannot anticipate but need. In short, it must strive to make the significant interesting and relevant. The effectiveness of a piece of journalism is measured both by how much a work engages its audience and enlightens it. This means journalists must continually ask what information has most value to citizens and in what form. While journalism should reach beyond such topics as government and public safety, a journalism overwhelmed by trivia and false significance ultimately engenders a trivial society. (§ 11)
8. “It must keep the news comprehensive and proportional
Keeping news in proportion and not leaving important things out are also cornerstones of truthfulness. Journalism is a form of cartography: it creates a map for citizens to navigate society. Inflating events for sensation, neglecting others, stereotyping or being disproportionately negative all make a less reliable map. The map also should include news of all our communities, not just those with attractive demographics. This is best achieved by newsrooms with a diversity of backgrounds and perspectives. The map is

only an analogy; proportion and comprehensiveness are subjective, yet their elusiveness does not lessen their significance. (§ 12)

9. “Its practitioners must be allowed to exercise their personal conscience. Every journalist must have a personal sense of ethics and responsibility — a moral compass. Each of us must be willing, if fairness and accuracy require, to voice differences with our colleagues, whether in the newsroom or the executive suite. News organizations do well to nurture this independence by encouraging individuals to speak their minds. This stimulates the intellectual diversity necessary to understand and accurately cover an increasingly diverse society. It is this diversity of minds and voices, not just numbers, that matters.” (§ 13)

Appendix D: Defining Waiting Times and Waiting Lists

Table 22

Select definitions of waiting times and waiting lists in Canadian literature

Source	Definition
Barer and Lewis (2000)	“A ‘waiting list’ for health care is a list of patients awaiting a service such as surgery or an appointment with a cardiologist” (p. 1).
Canadian Institute for Health Information (2005b)	In response to the frequently asked question, “Are there standard definitions for wait times?” the Canadian Institute for Health Information (2005a) wrote: “Historically wait time registries have developed definitions unique to their system’s goals and objectives and not all of these definitions are comparable. Thus there are currently no standard definitions regarding wait times. CIHI is, however, committed to working with partners towards establishing more comparable definitions” (p. 1).
Hadorn (2000)	“A waiting list is a queue of patients who are deemed to need a health service that is in short supply relative to demand. In effect, patients on waiting lists ‘reside’ in a common, imaginary ‘waiting room,’ with certain patients being called for treatment sooner than others. Two waiting lists are often operating: one to see the specialist who controls access to the desired service and another to receive the service once medical need has been verified. This second list is generally what is referred to by the unqualified term ‘waiting list,’ and almost all the existing data concern waits for services, not for evaluation, even though these ‘preliminary waits’ can sometimes be the longer of the two. Each waiting list is associated with an average waiting time, namely, the number of days, weeks or months expected to elapse from the time patients are placed on a list to the time they receive the service. Waiting time is determined by a complex interplay of factors, including system capacity, the number of patients on waiting lists and the number of emergencies arising while elective cases are waiting.” (p. 857).
Esmail and Walker (2006)	According to the Fraser Institute, there are two segments of waiting: the first is between referral by general practitioner and visit to a specialist for consultation; and the second is between the specialist’s decision that treatment is required and treatment.
Health Canada (2004a)	Waiting times are “the length of time it takes people to access health care services such as specialist services, diagnostics and treatment services” (¶ 1).
Health Council of Canada (2005)	“Enrollment (sic) on a wait list should take place at the time the intervention is formally booked (usually by a specialist). Both the original date of referral to the specialist and the booking date for the

	intervention should be recorded. The waiting interval should be defined as the time from initial referral to completion of the procedure” (p. 3).
McDonald et al. (1998)	“Waiting time refers to the length of time required for a patient on the list to receive the desired service. In most jurisdictions the length of time is a function of the manner in which patients enter the list and receive the service. Since methods show considerable variation, the meaning of the term ‘waiting time’ will vary according to its jurisdictional context” (p. 3).
Ministry of Health and Long-Term Care (2005)	First Ministers define waiting time as the number of days between a start date (when the patient and an appropriate physician agree to a service and the patient is ready to receive the service) and a finish date (when the patient receives the service or the initial service in a series).
Sanmartin, Barer, and Sheps (1998)	<p>“Waiting times represent the most important measure associated with waiting lists. In theory, waiting times represent the time between when patients are placed on the waiting list (i.e. ‘date on’) and when they are taken off the list (i.e. ‘date off’)” (p. 211).</p> <p>“The meaning of waiting list size is rarely defined but rather assumed to be the number of patients awaiting treatment at a particular point in time” (p. 216).</p>
Shortt (1998)	<p>“A <i>Waiting list</i> is generally held to be a roster of patients awaiting a particular health service. Such lists refer to elective rather than emergency services, though some lists are used for urgent services as well. They occur, in theory, when demand for a service exceeds immediately available supply and are particularly a characteristic of state-funded health care systems in which there is zero money cost for a service” (p. 2-3).</p> <p>“<i>Waiting time</i> refers to the length of time required for a patient on the list to receive the desired service. In most jurisdictions the length of time is a function of a manner in which patients enter the list and receive the service. Since methods show considerable variation, the meaning of the term of ‘waiting time’ will vary according to its jurisdictional context” (p. 3).</p>
Wait Time Alliance (2005a)	<p>“[T]he WTA operationally defines wait-time benchmarks as ‘<i>health system performance goals that reflect a broad consensus on medically reasonable wait times for health services delivered to patients</i>’” (p. 1).</p> <p>“The College of Family Physicians of Canada (CFPC) suggests that ‘the clock starts ticking long before a patient ends up in a specialist’s office.’ From the patient’s perspective, the wait may begin much sooner and at multiple points in the patient’s journey through the health care system. For the WTA (2005a), the patient’s wait time for</p>

specialty care begins at the point where he or she receives a differential diagnosis from the family physician/general practitioner; that is when 'wants' get translated into 'needs' and it is decided that the patient requires diagnostic testing or clinical intervention or both" (p. 2).

Appendix E: Defining Health Literacy

Table 23

Select definitions of health literacy

Source	Definition
Ad Hoc Committee on Health Literacy (1998)	The Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs of the American Medical Association defines health literacy with a skills-based view, as “. . . a constellation of skills, including the ability to perform basic reading and numerical skills required to function in the health care environment” (p. 553).
United States Department of Health and Human Services (2000)	In “Healthy People 2010,” the Office of Disease Prevention and Health Promotion of the U.S. Department of Health and Human Services defines health literacy as the capacity to obtain, interpret and understand basic health information and services and the competence to use such information and services to enhance health. This definition links health literacy to health promotion and prevention, moving the definition beyond one of functional health literacy.
World Health Organization (1998) / Nutbeam (1998)	The World Health Organization’s “Health Promotion Glossary” defines health literacy as representing “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health” (p. 10).
Nielsen-Bohlman, Panzer, and Kindig (2004)	The Institute of Medicine in the U.S. has established a Committee on Health Literacy, who define health literacy as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
Nutbeam (2000)	Nutbeam (2000) proposes three levels of health literacy, which include: (1) “functional health literacy” — basic reading and writing skills to be able to function in a health setting; (2) “interactive health literacy” — more advanced cognitive and social skills for active participation in health care; and (3) “critical health literacy” — involving the ability to critically analyse and use health information to actively participate to overcome structural barriers to health.
Parker and Gazmararian (2003)	Health literacy is “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (p. 116).
Parker, Ratzan, and Lurie (2003)	“Health literacy has many dimensions, including what it means to be able to read, understand, and communicate important medical and health information during different phases of life. Health literacy is central to multiple health system priorities, including quality, cost containment, safety, and patients’ involvement in health care decisions” (p. 147).
Ratzan and Parker	“Health literacy can be thought of as the currency needed to navigate

(1999) as cited in Parker & Gazmararian (2003)	and understand what you need to do” (p. 116).
Kirsch, Jungblut, Jenkins, and Kolstad (1993)	The authors of the 1992 National Adult Literacy Survey in the U.S. define “functional health literacy” as the ability to apply reading and numeracy skills in a health care setting. These skills include the ability to read consent forms, medicine labels and inserts, and other written health care information; understand written and oral information given by physicians, nurses, pharmacists and insurers; and act upon necessary procedures and directions such as medication and appointment schedules.
Gillis (2005)	Gillis (2005) provides a succinct definition of health literacy as an individual’s ability to (1) understand and use health information; (2) access appropriate services and supports; (3) make informed health decisions; and (4) gain greater control over their health and well-being.
Zarcadoolas, Pleasant, and Greer (2003)	The authors define health literacy “as the evolving skills and competencies needed to find, comprehend, evaluate, and use health information and concepts to make educated choices, reduce health risks, and improve quality of life. A health literate person is able to apply health concepts and information to novel situations. A health literate person is able to participate in ongoing public and private dialogues about health, medicine, scientific knowledge, and cultural beliefs. This dialogue, in turn, advances health literacy, individually and collectively” (p. 119). In their forthcoming book, <i>Health Literacy: Can the Public Be Healthy Without It?</i> the same authors propose a model for understanding and studying health literacy in terms of four domains: (1) “fundamental literacy/numeracy” — competence in comprehending and using printed and spoken language, numerals, and basic mathematical symbols and terms. Fundamental literacy affects a wide range of cognitive, behavioral, and social skills and abilities; (2) “science and technology literacy” — knowledge of fundamental health and scientific concepts, ability to comprehend technical complexity, understanding of common technology, and an understanding that scientific uncertainty is to be expected and that rapid change in the accepted science is possible; (3) “community/civic literacy” — knowledge about sources of information and about agendas and how to interpret them that enables citizens to engage in dialogue and decision-making. This domain includes media literacy skills and knowledge of civic and governmental processes; and (4) “cultural literacy” — recognizing and using collective beliefs, customs, world-views, and social identity relationships to interpret and act on (as well as produce) health information” (p. 120).
Zarcadoolas, Pleasant, and Greer (2005)	The authors suggest that a “health literate person is able to use health concepts and information generatively — applying information to novel situations. A health literate person is able to participate in the

ongoing public and private dialogues about health, medicine, scientific knowledge and cultural beliefs. Health literacy evolves over one's life and, like most complex human competencies, is impacted by health status as well as demographic, sociopolitical, psychosocial and cultural factors. Thus, the benefits of health literacy impact the full range of life's activities — home, work, society and culture” (p. 196). With this in mind, the authors define health literacy as “the wide range of skills, and competencies that people develop to seek out, comprehend, evaluate and use health information and concepts to make informed choices, reduce health risks and increase quality of life” (p. 196-197).

Appendix F: Quantitative versus Qualitative Content Analysis

Table 24

Comparing and contrasting traditional quantitative content analysis with qualitative (or ethnographic) content analysis

Characteristics	Quantitative content analysis	Qualitative (ethnographic) content analysis
Research goal	Verification	Discovery; verification
Reflexive research design	Seldom	Always
Emphasis	Reliability	Validity
Progression from data collection, analysis, interpretation	Serial	Reflexive; circular
Primary researcher involvement	Data analysis and interpretation	All phases
Sample	Random or stratified	Purposive and theoretical
Pre-constructed categories	All	Some
Training required to collect data	Little	Substantial
Type of data	Numbers	Numbers; narrative
Data entry points	Once	Multiple
Narrative description and comments	Seldom	Always
Concepts emerge during research	Seldom	Always
Data analysis	Statistical	Textual; statistical
Data presentation	Tables	Tables and text

Note. From "Ethnographic Content Analysis," by D. Altheide, 1987, *Qualitative sociology*, 10(1): 65-77.

Appendix G: Total Newspaper Documents Retrieved by Search Terms

Table 25

Total number of newspaper documents retrieved using the specified search terms, within the time period January 1, 2003 to December 31, 2005, searching within the headline and lead, for four Atlantic Canada daily newspapers: (1) The Chronicle-Herald (provincial edition) and its Sunday edition, The Sunday Herald; (2) The Guardian; (3) The New Brunswick Telegraph Journal; and (4) The Telegram

Newspaper	Search Term ^a	Original search results (number of newspaper documents) ^b
<i>The Chronicle-Herald</i> (Halifax, Nova Scotia)	waitlist	0
	waitlists	0
	wait list (wait-list)	13
	wait lists (wait-lists)	17
	wait time (wait-time)	22
	wait times (wait-times)	91
	waiting time	6
	waiting times	32
	waiting list	31
	waiting lists	47
	Total = 259	
<i>The Sunday Herald</i> (Halifax, Nova Scotia)	waitlist	0
	waitlists	0
	wait list (wait-list)	0
	wait lists (wait-lists)	0
	wait time (wait-time)	1
	wait times (wait-times)	2
	waiting time	0
	waiting times	4
	waiting list	0
	waiting lists	4
	Total = 11	
<i>The Guardian</i> (Charlottetown, Prince Edward Island)	waitlist	0
	waitlists	0
	wait list (wait-list)	2
	wait lists (wait-lists)	3
	wait time (wait-time)	6
	wait times (wait-times)	38
	waiting time	5

	waiting times	27
	waiting list	20
	waiting lists	21
	Total = 122	
<i>The New Brunswick Telegraph Journal</i> (Saint John, New Brunswick)	waitlist	0
	waitlists	0
	wait list (wait-list)	4
	wait lists (wait-lists)	2
	wait time (wait-time)	8
	wait times (wait-times)	33
	waiting time	6
	waiting times	18
	waiting list	28
	waiting lists	27
	Total = 126	
<i>The Telegram</i> (St. John's, Newfoundland and Labrador)	waitlist	0
	waitlists	1
	wait list (wait-list)	16
	wait lists (wait-lists)	14
	wait time (wait-time)	10
	wait times (wait-times)	41
	waiting time	8
	waiting times	21
	waiting list	14
	waiting lists	20
	Total = 145	

^aWith the exception of *The New Brunswick Telegraph Journal*, all of the searches were conducted using the newspaper archival database, Virtual News Library. The search for the remaining publication involved two databases: Virtual News Library and FP Infomart.

^bBefore duplicates and other rejected stories were taken out

Appendix H: Total Documents Retrieved Using Two Newspaper Databases

Table 26

Total number of newspaper documents retrieved using the specified search terms, within the specified search time periods, using two different newspaper archival databases (Virtual News Library and FP Infomart), searching within the headline and lead,^a and for two Atlantic Canada daily newspapers: (1) The New Brunswick Telegraph Journal; and (2) The Telegram

Newspaper AND Search Period	Search Term	Original search results (number of newspaper documents) using Virtual News Library ^b	Original search results (number of newspaper documents) using FP Infomart ^b
<i>The New Brunswick Telegraph Journal</i> (Saint John, New Brunswick) (January 1, 2003 to September 1, 2005)	waitlist	0	0
	waitlists	0	0
	wait list (wait-list)	2	1
	wait lists (wait-lists)	2	1
	wait time (wait-time)	4	4
	wait times (wait-times)	22	17
	waiting time	6	3
	waiting times	15	13
	waiting list	26	17
	waiting lists	26	23
Total		103	79
<i>The Telegram</i> (St. John's, Newfoundland and Labrador) (January 1, 2003 to December 31, 2005)	waitlist	0	0
	waitlists	1	1
	wait list (wait-list)	16	12
	wait lists (wait-lists)	14	13
	wait time (wait-time)	10	8
	wait times (wait-times)	41	34
	waiting time	8	9
	waiting times	21	17
	waiting list	14	9
	waiting lists	20	18
Total		145	121

^aVirtual News Library defines the lead as the first two paragraphs of a document, while FP Infomart defines it as the first paragraph of a document.

^bBefore duplicates and other rejected stories were taken out

Appendix I: Two Coding Strategies for Performing Qualitative Analysis

Holliday's (2002) six-step strategy for devising themes and using thematic headings to guide writing an inductive, thematic analysis argument:

1. "Look at the overall character of the corpus of data
2. "Search for natural divisions in the corpus
3. "Determine the character of each division
4. "Find headings that suit these divisions
5. "See how far the headings help make further sense of the data
6. "Use the headings to organize the writing" (p.105)

Rothe's (2000) 13-step strategy for performing qualitative surface analysis:

1. "Read data from beginning to end to capture its holism
2. "Extract major categories from each page of data and note them on the margins of the page. Don't hold back
3. "Name the categories and write them on 6x4 cards.
4. "Place the cards on the floor or on a work table.
5. "As you proceed through the pages of data, extract comments, categories you have already developed. Write the information on the cards, document the pages on which the data are found and place the cards in appropriate piles. If a new category is developed, add it to the theme cards. In short, group the information.
6. "Look for deviations of the categories, which may produce alternative categories or sub-categories.
7. "Constantly compare new information with information you have already categorized. How is this instance of X similar to or different from previous instances? How is X in this setting similar or different from X in another setting? (See Lofland and Lofland, 1984.)
8. "As you do this, always think about the total picture and how the categories fit, or do not fit, into a total design. Jot down some of your thoughts for a large frame.
9. "Begin to shuffle the category cards for data that may overlap two or more categories.
10. "Re-read the data from front to back to re-acquaint yourself with the stream of events of which your cards are pieces.
11. "Begin synthesizing the categories from their data and subcategories, and develop themes.
12. "Merge the themes to compose patterns of behaviour.
13. "Establish theoretical, policy or organizational implications of the data" (p. 142-143).

Appendix J: List of Acronyms

CCJ: Committee of Concerned Journalists

CHSRF: Canadian Health Services Research Foundation

CIHI: Canadian Institute for Health Information

CIHR: Canadian Institutes of Health Research

CMA: Canadian Medical Association

FPT: federal, provincial, and territorial

HCC: Health Council of Canada

HRT: hormone replacement therapy

HPV: human papillomavirus

IHSPR: Institute of Health Services and Policy Research

NADbank: Newspaper Audience Databank Inc.

NGO: non-governmental organization

PHAC: Public Health Agency of Canada

SARS: Severe Acute Respiratory Syndrome

WCWL: Western Canada Waiting List Project

WHI: Women's Health Initiative

WHO: World Health Organization

WTA: Wait Time Alliance

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