

Waiting Times for Surgery in Manitoba



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THE MANITOBA CENTRE FOR HEALTH POLICY AND EVALUATION

The wait for surgery. It's a topic of ongoing concern in this province. Those concerned contend that Manitobans waiting to have surgery—regardless of the procedure—are waiting longer and longer. But are we in fact waiting longer for surgery today than we were five years ago?

That question is at the heart of this report by MCHPE. We undertook this study of waiting times for surgery at the request of Manitoba Health, due to public perceptions and concerns about the issue. Not only do we look at available data on wait times for several surgical procedures, our report also explores some key issues—When does a waiting time start? Have waiting times changed? Do certain groups get surgery faster? We also examine the complexities involved in setting up a bona fide waiting list—a centralized registry to monitor waiting times. Currently, we don't have one in Manitoba.

That's right. Contrary to widespread assumptions, with the exception of cardiac surgery, there is no actual "waiting list" for surgery in this province. There's no system that keeps track of how many people are waiting, or for which procedure, or for how long—much less with criteria for prioritizing patients, such as indicators of pain or impairment.

So, with no specific Manitoba data saying when surgery was agreed upon, we

had to find a method of measuring the length of the wait. Fundamental to that was finding a marker—a starting point if you will—for when a wait began. This marker had to be present in a high proportion of cases, and it had to make sense to clinicians.¹

Using computerized data from Manitoba Health, we chose the pre-operative visit to the operating physician as the marker for the procedures we studied. The underlying assumption here is that the family physician refers the patient to a surgeon, who together with the patient then makes the decision to operate (start of wait), after which the patient is not seen again by the surgeon until surgery (end of wait).

We studied wait times in each year between 1992 and 1996 for eight non-emergency surgical procedures (fig.1). We chose these because they are commonly performed and represent a good mix of procedures. Also, some of them (e.g. hernia and varicose vein repair) are easily delayed, so if access is a problem, we'd expect very long waits for them. We also reviewed two coronary procedures—bypass surgery and angioplasty. Last but not least, we looked at cataract surgery, but because it is offered in both the public sector and in privately-operated clinics, we examined it separately.

1. A Working Group was set up to advise on the project. It included a number of doctors—a family practitioner, a heart surgeon and a general surgeon—as well as representatives from the Consumers Association of Canada and the Manitoba Society of Seniors. In addition, we asked for advice from an orthopaedic surgeon and an ophthalmologist.

In addition, we checked to see if the wait was affected by non-medical factors like where patients lived, neighbourhood income, gender and age.

Findings

We calculated the median waiting time for all procedures. The median is the mid-point, meaning half the patients waited more time, half waited less time.

For the five years combined, waiting times for five of the eight core procedures were from 25 to 35 days. For breast tumour surgery the wait was 16 days. The longest waits were for varicose vein repair at 40 days and tonsillectomy at 51 days (fig.1).

Did the waits for these eight procedures get longer from 92 to 96? For the most part no. Only two increased—varicose vein repair by 13 days and carpal tunnel release by 8 days. Meanwhile, three wait times shortened by 4 to 7 days: gallbladder removal, prostate surgery and tonsillectomy.

Coronary Procedures

For coronary bypass and coronary angioplasty we looked at seven years of data, from 1990 to 1996. In every year, roughly half of patients having a bypass were admitted as *urgent*. For

them, the waiting time was 3 to 5 days. For non-emergency patients the waits decreased over time; a 60-day wait in 1990 dropped to 40 days in 1996.

We also found a decrease in the number of *delayed* patients—those who wait longer than three months for bypass surgery (ideally the wait should be less than three months). In 1990 and 1991, 39% to 40% of bypasses were delayed; in 1996 that number dropped to 24%.

Coronary Angioplasty

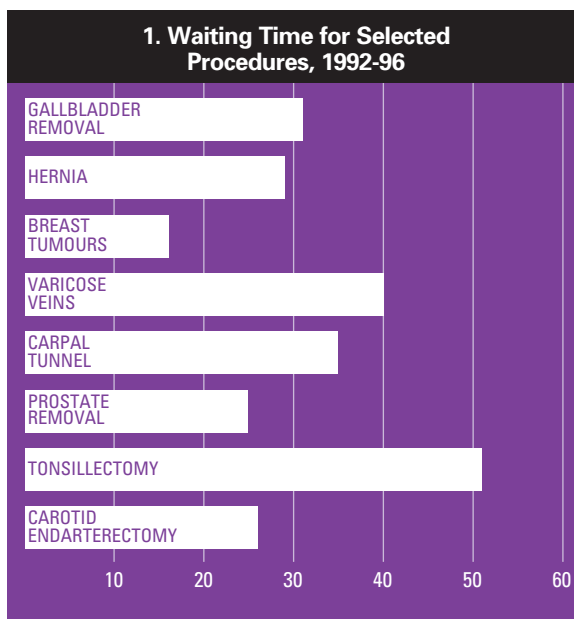
Up and down is the best way to describe the pattern of wait times for coronary angioplasty. For patients coded as *urgent*, the median wait was from 4 to 7 days. When we compared patients who waited more than three days, an irregular pattern emerged: overall the wait worked out to 32 days, but was lower in 92, 94, and 95; higher in 90, 91, 93 and 96. The proportion of delayed angioplasty patients also fluctuated from year to year, but remained under 20%.

Cataract Surgery

During this study, cataract surgery was available privately as well as publicly (through medicare) in Manitoba. Some eye surgeons operate only in the public sector; others have both public and private patients. At both the hospital and the private clinic, Manitoba Health pays the surgeon's fee. What patients pay at a private clinic is a "facility" or "tray" fee, typically \$1000. Recent legislation will put an end to this extra billing.

One of the arguments in favour of permitting private surgery along side medicare is that it can offer faster service. And we did find that cataract waiting times were shorter in a private clinic compared to the public hospital. The median wait for surgery in a private clinic was about four weeks, and remained stable from 1992 through 1996. The median wait for surgery in the public system was 16 weeks in 1992, fell to 11 weeks in 1994, and rose to 18 weeks in 1996.

A much different pattern emerged when we separated patients whose doctors only performed publicly-funded cataract surgery from those whose doctors also do privately-funded surgery (fig. 2). For surgeons who operated



Median wait in days after patient sees surgeon pre-op

only in the public sector, the wait was around 7 weeks in 1993-95, increasing to 10 weeks in 1996. But for surgeons who performed both private and public procedures, their patients scheduled for in-hospital surgery waited about 14 weeks in 1993 and 1994, up to 23 weeks in 1996. So patients awaiting public sector surgery would wait up to 13 weeks longer if their surgeon also operated privately.

An increase in a wait time does not automatically mean, as some might assume, that there are fewer procedures being performed. While it is true that wait times for cataract surgery have increased, the number of public cataract procedures has actually jumped 32% from 4,265 in 1992 to 5,619 in 1996. There is more cataract surgery being done in hospital now than ever before.

Non-Medical Influences

Group to group, region to region, Manitobans' waits are alike: rural patients do not wait longer than those living in Winnipeg or Brandon; women are not kept waiting longer than men. Nor are the wealthy "bumped up" ahead of middle- or low-income patients. Seniors tend to have surgery sooner, possibly because retired people have more flexible schedules than do people in the work-force.

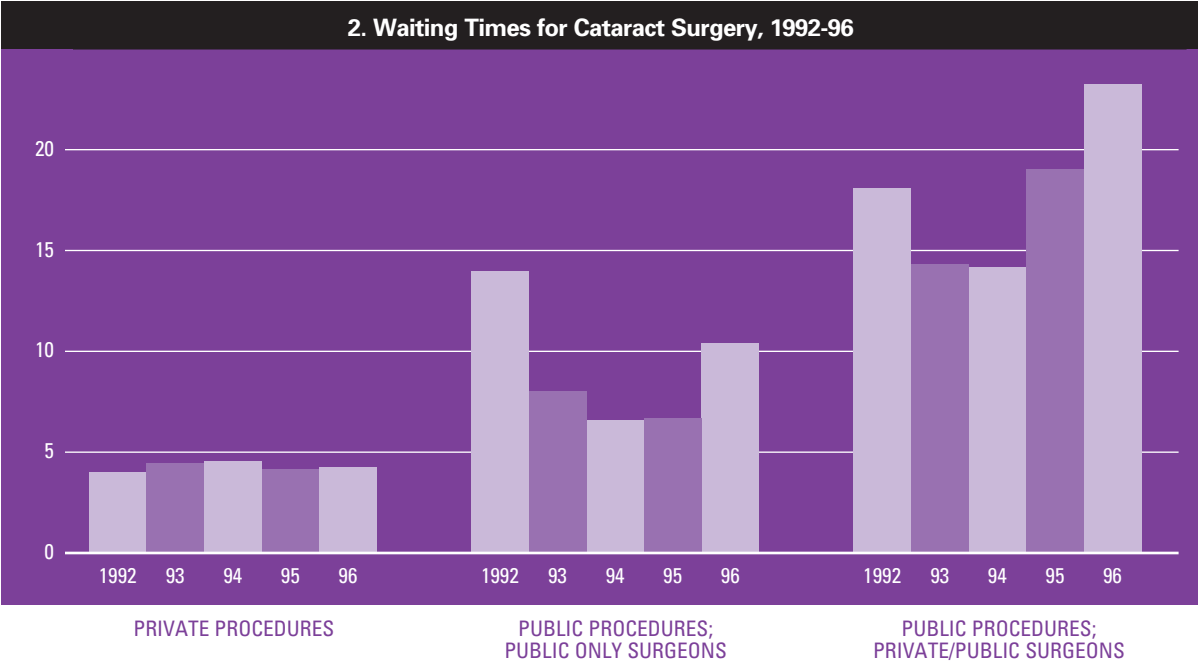
Conclusions

Contrary to what is all-too-often reported, waiting times for surgery in this province have remained fairly stable. Nothing suggests a pattern of increase. In fact, for the procedures we studied, the few where waits increased were outnumbered by those where waits decreased.

That's not to suggest there is nothing of concern. For instance, while the median wait for coronary angioplasty has been up and down over the last seven years, it is up in our most recent year of study, and a smaller proportion of patients received the procedure within 30 days of angiogram. So it will be important to assess whether this is the beginning of a trend or merely another random fluctuation.

Waiting times are a concern in any publicly financed health care system. Those in favour of privatization—as in the US—condemn the public system as rationing care. But in the US, those who can't pay are denied care—what greater rationing is there than that? From our analysis of the problems that can develop in a mixed private/public system, it appears that Manitoba has made the right choice in moving away from letting surgeons extra-bill patients.

Furthermore, patients may be more tolerant of waiting than we suppose. A recent study of Manitoba cataract patients suggests a great



deal of satisfaction with the public system. Almost 75% of them thought their wait for surgery was reasonable, 85% were against more taxes to shorten or eliminate waits, and fewer than 2% opted for private surgery.

Patients who do opt for private surgery do so to save time. According to Manitoba Health, some patients reported that it was a choice between waiting one month for private surgery, or up to 24 months for public surgery—by the same surgeon. But did these patients know that if they went to a different surgeon, one with no private practice, they might have had the surgery, funded by medicare, in just over two months?

Two points seem clear. First, some cataract surgeons are busier than others; their long wait times are more a comment on how busy each one is, not on how long wait times are. Second, better information is needed. Knowing how busy each surgeon is, perhaps some patients would choose to see a less busy one. Of course, such migrations would lead to changes; less busy surgeons would get more busy and vice versa. Conceivably, over time the waiting times would begin to balance out.

The assortment of wait times for cataract surgery also makes an argument for a waiting list to manage the waiting process better. The Misericordia Hospital (where all Winnipeg's public cataract surgery is performed) recently started such a list. It considers not only how long cataract patients have been waiting, but how severely their sight is affected.

This raises the question of setting up a central registry for other types of surgical procedures. But if such a registry was to be established here in Manitoba, research elsewhere where waiting lists are kept suggest a number of pitfalls:

- How is the start time determined? It should indicate that the patient has agreed to surgery, is available, and has had all the relevant tests. If a surgical date is offered and not accepted, the reason for the delay should be noted.

- Ranking according to need is difficult. Among many considerations: how long has the patient been waiting, degree of pain and disability, expected progression of the disease, anticipated benefits of the procedure, and employment considerations.
- Physician practices vary; some opt for surgery sooner than others, so they have more patients waiting and their patients appear to wait longer.
- Waiting list management is challenging. Double-booking, patients postponing surgery or being unavailable, and improvement in a patient's health can make such lists inaccurate.

The method used in this study can monitor waits, but it has a few drawbacks. It can only be applied after the surgery has taken place, so it doesn't tell you anything about patients who are still waiting for surgery. It can't be used to monitor the wait for diagnostic tests. Nor can it be used to tell us about the wait for surgery for chronic conditions—like hip replacement—which often require more than one pre-operative visit to the surgeon.

Nevertheless, with the increasing importance of managing health care resources, the need to routinely collect data to monitor waits seems clear. True, we've been able to answer some questions—Are waiting times for surgery in Manitoba getting longer? No; Are certain groups like the wealthy or people living in Winnipeg jumping ahead of others? No. But given the continuing concern about waiting times in Canada, getting those answers should be easier. A system that considers areas of public concern (most recently joint replacement and some diagnostic tests), that collects data for managing resources, and that prioritizes patients according to some agreed-upon measure of need, would go a long way to that end.

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