



JUNE
2007

Surgical Waits in Manitoba: Up? Down? No Change?

MANITOBA CENTRE FOR HEALTH POLICY

Summary by RJ Currie,
based on the report:
*Waiting Times for
Surgery, Manitoba:
1999/2000 to 2003/2004*
by Carolyn De Coster,
Dan Chateau,
Matt Dahl,
Ruth-Ann Soodeen,
and Nancy McKeen.

Waits studied for
13 non-emergency
procedures

Coronary bypass down
from 58 days to 41

Heart valve
replacement down
from 77 days to 65

Cataract surgery down
from 22 weeks to 16

Hip replacements up
from 12 weeks to 28

Knee replacements up
from 15 weeks to 31

Eight other procedures:
4 no change, 4 up

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.

Sound familiar?

It might. Wait times are a regular item of interest in the media these days. But it may sound familiar for another reason; this introduction is taken from our first look at wait times back in 1997.

It seems, as the old saying goes, that the more things change, the more they stay the same. Waits are still a hot topic. The public has the same perceptions, the same concerns that they had ten years ago.

So are all surgical waits getting longer? No. Of the thirteen procedures we studied, three waits got shorter, four stayed about the same, while six got longer. More importantly perhaps, when we look only at the four life-saving procedures, none of those waits got longer. In fact, some got shorter.

These are some of the key findings in this, MCHP's third look at waiting times for surgery. It was undertaken at the request of Manitoba Health, in part due to ongoing public concerns about the issue. This time we use data from April 1, 1999 to March 31, 2004, comparing median waits (a median is the mid-point, so half the patients waited more time, half waited less) across that five-year period.

In the full report, we also offer some comparisons to waits observed in our earlier reports. However, because our methods have changed and include data not

available then, our focus here is on the year-to-year trends across the five years of this study.

As before, we look at the same core group of eight surgeries (Fig. 1), chosen because they are routinely performed and represent a cross-section of procedures. Also, some of them (like hernia and varicose vein repair) are easily delayed, so if access is a problem, we'd expect their waits to be getting longer.

Also as before, we look at cataract and bypass surgery. But this time around we've added heart valve replacement and hip and knee replacement (Fig. 2). Along the way, we visit or revisit some key issues: When does a waiting time start? Do people in certain areas get surgery faster? How do registry waits compare to what we find?

A Working Group was set up to assist us. They provided important feedback on our methods, analysis, and the interpretation of findings. Their experience at the front lines of patient care gave us valuable insights.

One final point we want to make is that the wait times in this study don't include those done as emergencies.

Defining Waits

When does a waiting time start? That's always a key question anywhere waits are measured. For most procedures (though not all) there isn't a single system that keeps track of how many people are waiting, or for which procedures, or for how long. What the public generally thinks of as a "waiting list" for surgery is actually



UNIVERSITY
OF MANITOBA

a series of different lists kept by surgeons, clinics and hospitals.

With no central source on most waiting times, we couldn't simply look up how long patients have been waiting for surgery. So, as we did in our earlier looks at waits, we chose the pre-operative visit to the surgeon as our starting marker. 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).

This method is not unique. It's been used in other provinces and is a lot less expensive than other methods.

Almost all our information comes from the population health database at MCHP which we call the *Repository*. We also make use of registry data from the Winnipeg Regional Health Authority (WRHA) for three procedures—cardiac, cataract, and total hip/knee replacement. Such registry data is one way that this look at waits differs from our previous two.

These registries keep track of people who are waiting for a particular procedure. When patients agree to have surgery, their names and usually some demographic information are submitted to the registry office. When

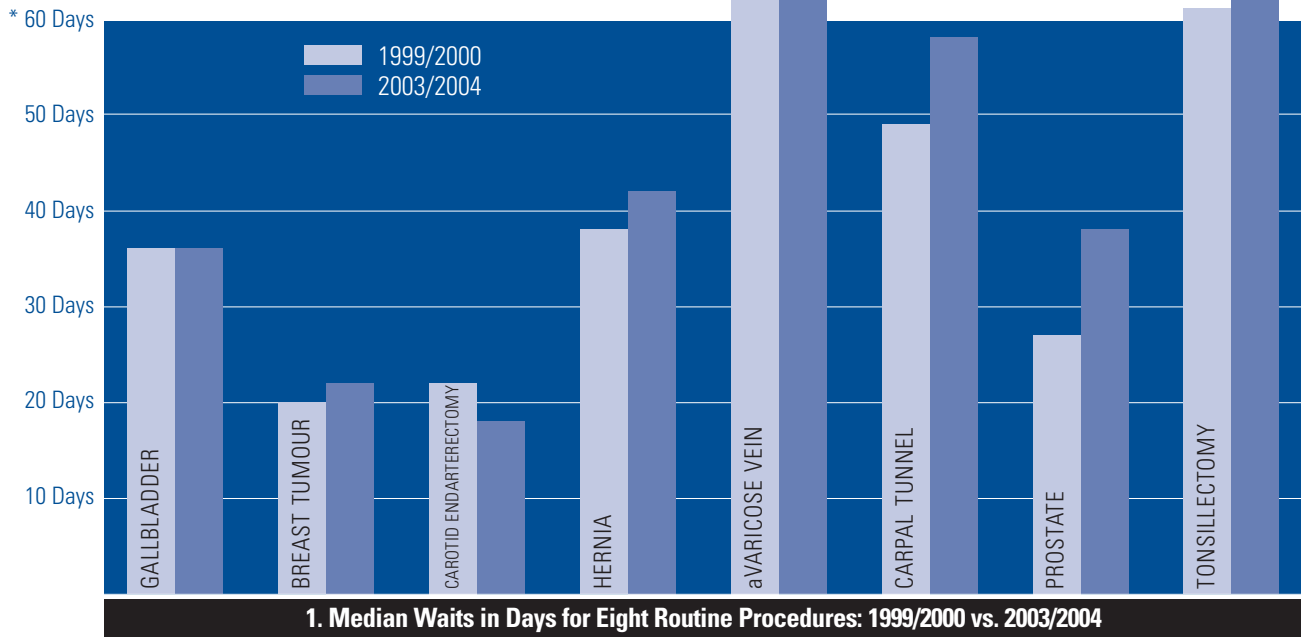
each has their surgery, the date is entered so that the wait time can be calculated.

Some registries also include an assessment of urgency. For instance, the cardiac registry calculates an urgency rating for bypass and a recommended maximum wait time. The cataract registry has a priority score which is based on the patient's answers about their visual problems, and the length of time the patient has been waiting.

Registries can tell you how many people are waiting at any particular time and the average length of the wait. But problems can exist with registries. For example, how is the start of the wait time defined? Are there patients in the registry who should be removed because they no longer need the procedure, are too sick for the procedure, have moved or died? Are there patients double-counted in the registry? Is the registry complete?

For example, one problem with the WRHA hip/knee replacement registry was that it was voluntary at the time of the study. As a result, not all physicians participated, or did so only part of the time; so many of their procedures aren't in the registry.

This underscores one important benefit of using



* Most waits are less than two months

the kind of data housed in the Repository to monitor waits: it includes all cases. However, in almost all instances registry-based waits are very close to Repository-based waits. In the interests of being unbiased, where there is a big difference between the two, we report the longer wait.

What’s Up? What’s Down?

A wait that is up or down by less than a week is reported as *no change*. Waits that are more than 100 days are expressed in weeks.

- ❑ Bypass down from 58 days to 41
- ❑ Valve replacement down from 77 days to 65
- ❑ Cataract surgery up at first, from 22 weeks to 25, then down by study’s end to 16 weeks—a 6 week drop overall
- ❑ Gallbladder removal, breast tumour removal, carotid endarterectomy (a stroke-preventing procedure) and hernia repair: no change; shortest median wait 18 days, longest 42
- ❑ Varicose vein repair up from 62 days to 93
- ❑ Carpal tunnel up from 49 days to 58
- ❑ Prostate surgery (non-cancerous) up from 27 days to 38
- ❑ Tonsillectomy up from 61 days to 70
- ❑ Hip replacement up from 12 weeks to 28
- ❑ Knee replacement up from 15 weeks to 31

Some other findings of note:

- ❑ Age, sex or neighbourhood income levels don’t appear to affect waits
- ❑ Nor-Man and Central RHAs have the shortest waits; Brandon and South Eastman have the longest waits

This last bullet may come as a surprise. It goes against the popular perception that access to care is worse in more remote areas—like Nor-Man—and better in urban centres—like Brandon.

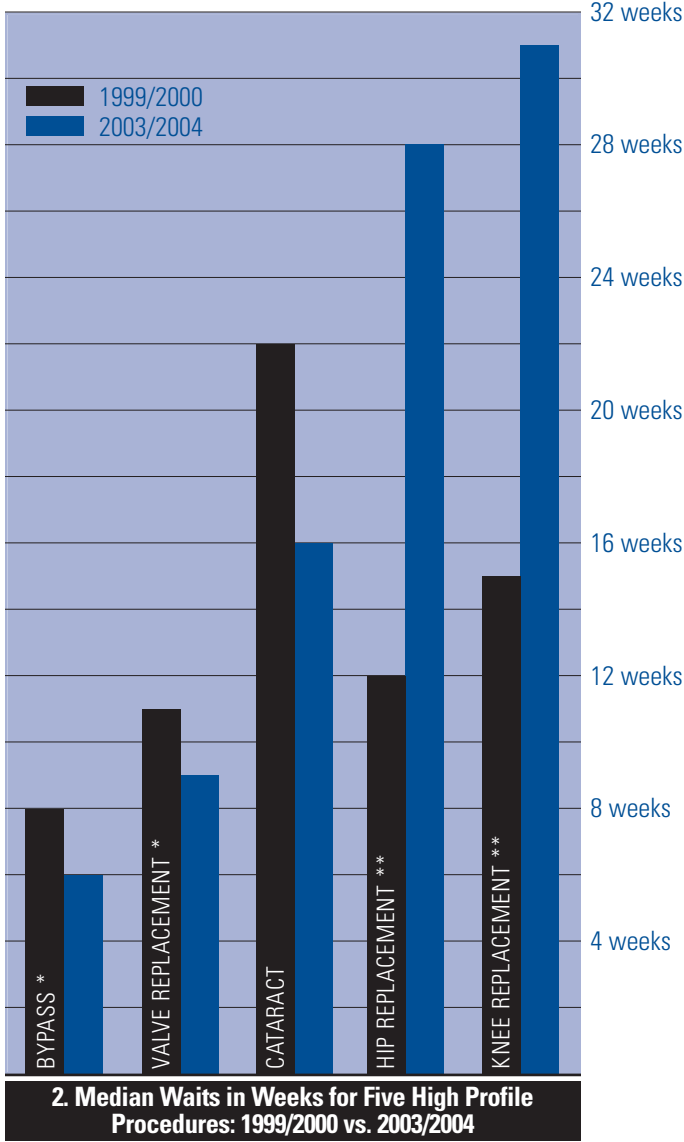
The Long and Short of It

The news about waiting times for surgery in Manitoba is mixed.

On the good news side, waits for the life-threatening procedures we studied—cardiac, breast tumour and carotid artery procedures—are shorter overall. Waits for cardiac procedures in particular are down noticeably. The median wait for bypass is down from 58 days

to 41. Waits for valve replacement are down from 77 days to 65. The death rate for patients awaiting cardiac surgery is very low at only 0.6%—much lower than rates reported elsewhere.

Also good news—and likely surprising to many Manitobans given what is often portrayed in the media—is that roughly two-thirds of the waits we looked at are about two months or less. It is also reassuring that, whether male or female, wealthy or poor, young or old, Manitobans experience similar waiting times.



* Rounded to nearest week for comparison purposes
 ** Start year 2000/2001 as data not available for 1999/2000

What isn't good news is that of the thirteen waits we studied, twice as many are up as are down. Waits for hip/knee replacement in particular took a big jump. And of the eight routine surgeries studied (Fig. 1), only one wait is shorter, and that by just a few days. So from this perspective, waits overall are getting longer. And whenever a surgical wait increases it's a concern.

The instinctive response to increased waits is typically either a) more procedures will shorten waits, or b) we need private medicine.

Let's talk about private medicine first. When there was private cataract surgery in Manitoba, public-sector waits got longer. (Manitoba Health decided to ban private cataract surgery in 1998.) In the United Kingdom, areas with the longest waits for public-sector surgery are also those with the most private beds, and the long-wait procedures are those where there is the most private practice. Private medicine shortens waits? Hardly.

The more-procedures argument has a lot of complexities. Support for this argument can be found in cataract surgery and bypass: the rates increased over the past five years and the median waits declined. But hip/knee replacement flies in the face of this argument—procedures are up by about 8%, yet waits are more than double. Or look at carotid endarterectomy: rates fell, but waits didn't get longer, they got shorter.

And the more-procedures argument doesn't hold up when you compare in-region services available to RHAs. The proportion of in-RHA vs. out-of-RHA surgery is the same in South Eastman as it is in Nor-Man. So their waits should be similar, right? Wrong, Nor-Man's waits are shorter.

The more-procedures argument has other limitations. It assumes that there are operating rooms sitting around idle, but it could be that all operating rooms are at capacity. It also assumes that surgeons are not as busy as they could be—highly unlikely—or that there are spare surgeons, anaesthetists, nurses and other hospital staff waiting to take up the slack—which of course, isn't the case.

So while it is generally true that increasing the number of procedures leads to shorter waits, it's far from that straightforward. In fact, it could be that doing more of one procedure might be akin to squeezing a tube of toothpaste: you get a bulge in one spot, a shrinkage in another; more of one procedure may mean less of another.

This could be what is happening here in Manitoba. The number of cardiac surgeries and hip and knee replacements is up. Has it been at the expense of other procedures? Is this why varicose vein repair and carpal tunnel waits are longer? It's possible.

Another possible explanation is that supply can't keep up with demand. Take, for example, hip and knee replacement. It's not a big leap to think that a lot of baby boomers are hitting the age where they need these procedures. This could be why, after the period of this study, Manitoba Health has funded 1000 more hip/knee replacements per year.

One thing we know contributes to surgical waits—as it always has—is that surgeries drop over the summer months. This is nothing new, but perhaps needs to be looked at. A small part may be due to patients or surgeons, but mostly it's due to summer vacation by hospital staff. So one possible way to shorten overall waits might be to develop a system that keeps operating rooms busier in the summer.

A footnote to all of this is that since the period of this study, Manitoba received \$155 million from the federal *Wait Times Reduction Fund*. It's an initiative aimed essentially at reducing waits in several key areas. As it relates to this study, heart, sight restoration and joint replacement are among its priority areas.

So one could say it's good news that in Manitoba, the number of cardiac, cataract and hip and knee replacement procedures is on the rise. But is the glass half full or half empty? Has the increase in the number of these "key" surgeries led to the decrease we see in others? Is this why some waits are up in our province? Is this an on-going trend? The answers will have to wait for another study.

WANT THE COMPLETE REPORT?

YOU CAN DOWNLOAD IT FROM OUR WEB SITE: www.umanitoba.ca/centres/mchp/
OR ORDER IT FROM MCHP: PH. (204) 789-3819; FAX (204) 789-3910; EMAIL reports@cpe.umanitoba.ca
Manitoba Centre for Health Policy, University of Manitoba, Winnipeg, Manitoba, R3E 3P5