

Waiting Times for Surgery in Manitoba: A Second Look



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THE MANITOBA CENTRE FOR HEALTH POLICY AND EVALUATION

In 1998, MCHPE released its first report on surgical waiting times in Manitoba. The main question it asked was: Are waits for surgery longer than they were five to seven years earlier? The answers at that time, for the most part, were no. This report follows up that earlier work, adding two more years of data. The main question is much the same, but some answers have changed.

This report, undertaken at the request of Manitoba Health, looks at data from 1997/98 and 1998/99. It compares median waits (a median is the mid-point, meaning half the patients waited more time, half waited less) to the five-year medians from the previous report. Again, we look at eight non-emergency surgical procedures (figure 1), chosen because they are commonly performed and represent a good mix. 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.

Two coronary procedures—bypass surgery and angioplasty—are also revisited (for these, the first report looked at seven years of data). Last but not least, we look at cataract surgery, but because it was offered at the time in both the public sector and in privately-operated clinics, it is examined separately.

As mentioned in the previous report, a key question in assessing waiting times is: When does a waiting time start? For most procedures there isn't a single sys-

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

So, with no central data source on waiting times, we can't simply look up how long patients were waiting for surgery. We had to come up with our own "measuring stick" using the data that were available, such as visits to physicians. Fundamental to that was finding a marker—a starting point if you will—for when a wait began.

We chose the pre-operative visit to the surgeon 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). Conditions that typically require several pre-operative visits, such as joint replacement, could not be studied using this method.

Coronary procedures

For coronary procedures we looked at both urgent and non-emergency (elective or scheduled) procedures.

- Between 96/97 and 98/99, the rate of bypass increased 16%. The rate of angioplasty increased 6%.

- ❑ Urgent waits didn't change, averaging three to five days.
- ❑ Waits for elective coronary artery bypass were 33 days in 97/98, then dropped to 26 days in 98/99, much shorter than the previous median of 48 days.
- ❑ A higher proportion of elective patients received surgery within 90 days (figure 2), continuing a trend from the first report. (Ideally, elective patients should receive surgery within ninety days.)
- ❑ The median wait for elective angioplasty was up and down compared to the previous report, when it was 32 days. The wait was five days longer in 97/98 at 37 days, one day shorter in 98/99 at 31 days.



Waiting time in days after pre-op visit to surgeon

Cataract surgery

Private cataract surgery ended in Manitoba in January 1999. Until then, patients who had cataract surgery in a private clinic were required to pay a “tray” or “facility” fee of approximately \$1000. Since then, though cataract surgery is performed in both public hospitals and privately-owned clinics, Manitoba Health covers all costs.

- ❑ The public-sector waiting time was 17 weeks, which was longer than the previous median of 13 weeks. Yet, the rates of public cataract surgery rose 13%
- ❑ Waits for private cataract surgery increased from four weeks to five.
- ❑ In the last year of the previous report, public sector waits were 17 weeks, matching waits in this report, suggesting perhaps a leveling off. Private sector waits compared to the last year of the previous report rose 23%.
- ❑ As in the previous study, waits for public-sector surgery were shorter if one's surgeon operated only in the public sector. In both 97/98 and 98/99 these waits were 10 weeks. Waits for public surgery by surgeons who had both public and private practices were 21 weeks in 97/98 and 26 weeks 98/99.
- ❑ Waits were similar regardless of where in Manitoba one lived and regardless of neighbourhood income level.
- ❑ Women had waits for cataract surgery about three weeks longer than men.
- ❑ Not surprisingly, people from the highest income neighbourhoods had more private surgery than people from lower income neighbourhoods: 32% compared to 20%.

Selected routine procedures

We studied eight routinely-performed surgical procedures. Although all of these surgeries are “elective” in the sense of being scheduled, some are more necessary than others: breast tumour surgery and carotid endarterectomy are less discretionary; tonsillectomy and varicose vein repair are more discretionary.

- ❑ In 98/99, waits for six of the eight procedures were two to six days longer compared to 92/93-96/97 (figure 1).
- ❑ Two of the procedures, carpal tunnel release and varicose vein repair, had waits more than ten days longer in 98/99 compared to 92/93-96/97.
- ❑ For all of the procedures except carotid endarterectomy, patients from either Winnipeg or the West (South Westman, Marquette and Brandon RHAs) had a significantly longer wait than the Manitoba median. Patients in the South (Central and South Eastman RHAs) had a shorter wait than the Manitoba median for four procedures. Patients in the remaining RHAs had waits the same as the Manitoba median.
- ❑ Waits were similar by age, gender and neighbourhood income level. This differed from the previous report, where older patients tended to have the shortest waits.

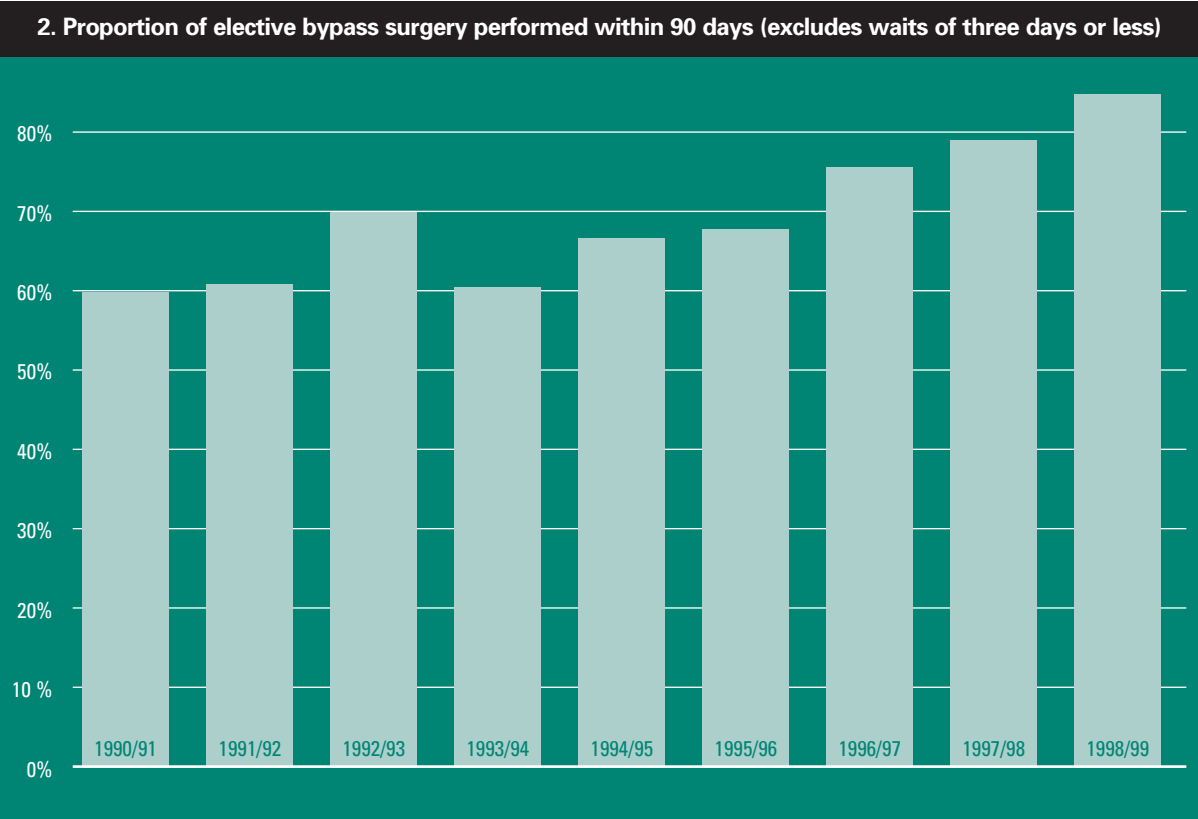
Discussion

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

The good news is that waits for bypass surgery are getting shorter. And a bigger proportion of patients receive their surgery within 90 days. Also reassuring is that, whether male or female, wealthy or poor, young or old, Manitobans experience similar waiting times.

Also good news is the fact that for all procedures (except cataract surgery) waits were less than 60 days. For many of them, the wait was around 30 days. Since patients should have enough time to weigh the risks and benefits of surgery, a thirty day wait is quite appropriate.

What isn't good news is that waiting times for elective surgery seem to be on the rise. For instance, the wait for breast tumour surgery went from 16 days in the last reporting period to 20 days in this one. The wait for carotid endarterectomy went from 26 days to 32 days. While it's true that the actual number of days these waits increased—four for breast tumour surgery and six for carotid endarterectomy—



isn't alarming, it's the trend towards increasing waits that is of concern.

Do these trends indicate that Manitobans' access to care is decreasing? The answer is far from straightforward.

The instinctive response to increased waits is: "we need more resources." Support for this argument can be found in coronary bypass surgery: the rate increased over the past five years and the median waiting times declined.

But the argument doesn't hold up against all procedures. When we look at public-sector cataract surgery, the number of operations increased 52% between 92/93 and 98/99, and the rate of surgery, even after adjusting for the increased number of elderly, increased 43%. But the median waiting times fell only briefly, then increased again.

Prostate surgery shows yet a different pattern. The number of procedures fell from 1223 in 92/93 to 786 in 94/95. Despite fewer procedures being performed, waits got shorter not longer—from 30 to 25 days. Then the number of procedures increased after 94/95 to 928, yet waits also rose, climbing back up to 30 days. So, for prostate and cataract surgery, an increase in resources didn't shorten waits.

Or consider the fact that only two of the eleven surgeries we've studied saw their surgical rates drop in this report compared to last. Meanwhile, six of the surgical rates increased. Yet overall, waiting times are up. Clearly then, there is more to managing waiting times than increasing resources.

Nor does private medicine help shorten waits in the public sector. For all but the last three months we studied, cataract surgery was available both publicly and privately. We found that waiting times for cataract surgery in the public sector were longest for those patients whose surgeons also operated privately.

This pattern has also been noted in the United Kingdom, where areas with the longest waits for public-sector surgery are those with the most private beds, and the long-wait procedures are those where there is the most private

practice. Findings such as these contributed to Manitoba Health's decision to ban private cataract surgery.

The reasons for such findings are not clear. One theory is that surgeons with private clinics have an incentive to have long public-sector waiting lists. That's not to say that they are "padding" their public-sector waiting lists by recommending surgery unnecessarily. But they might recommend surgery more readily, for cases that are less serious, than another surgeon might. So depending on the way each surgeon manages his or her wait list, some patients might receive surgery before others who need it more. This is true not only of cataract surgery, but of elective surgery generally.

Which underscores a point made in the last report, and worth making again. A system is required that prioritizes patients based on some agreed-upon measure of need—such as severity of illness, pain and discomfort, activity limitation, urgency, and expected benefit. In addition, information on waiting times for individual surgeons should be readily available, to assist patients and primary care physicians in selecting specialists. Such an information system might also "red flag" patients whose waits seem excessively long. It could reprioritize patients based on their changing conditions, and remove from the list those who are no longer waiting, such as patients who move or decide against surgery.

In the end, we have what seems to be a paradox. Overall, the surgical waits we studied are up slightly; yet overall, there are more of these procedures being performed than ever before. How can this be? The answers are complex and beyond the scope of this study. What we can say for sure is that a more centralized, provincial system on waits would make those answers a lot less elusive.

Summary by RJ Currie, based on the report: Waiting Times for Surgery: 1997/98 and 1998/99 Update by Carolyn De Coster, Leonard MacWilliam and Randy Walld.

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