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**CRITICAL ISSUES**

*bulletin*

Waiting Your Turn

Hospital Waiting Lists in Canada

(9th edition)

*by Michael Walker  
and Martin Zelder*



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## Critical Issues Bulletins

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# Preface

This *Critical Issues Bulletin* is the Institute's ninth attempt to document the extent to which queues for visits to specialists and for diagnostic and surgical procedures are being used to control health care expenses. When we began producing waiting-list measures in 1988, there was anecdotal evidence that hospital waiting times were becoming significant. However, there were no systematic measurements of the extent of waiting.

Partial waiting-list measurements made by hospitals and government departments were viewed as politically sensitive and were not made generally available. While these official waiting lists are now more readily accessible, they are still incomplete, meaning that there are no comprehensive measures other than those produced by The Fraser Institute by which to measure the length of waiting lists in Canada.

The contents of the survey have been corroborated to the extent possible by recourse to other sources of information. In particular, copies of the preliminary drafts of the

study were sent to all of the provincial ministers of health for their comments. Also, facilities-based estimates of waiting times (e.g., cardiovascular surgery) have been used to supplement the survey results.

Measurement is crucial to understanding how any system works; where those systems contain problems, it is the key to finding solutions. Largely as a result of the intense public interest in our past publications, waiting lists are now a component of any serious debate on the health care system in Canada. We hope that this interest in waiting lists continues and that Canadian policymakers begin to consider seriously the implications of queuing as they design alternatives to our present health care arrangements.

While this study and its widespread distribution has been enthusiastically supported by The Fraser Institute, the work has been independently conducted and the views expressed may or may not conform to those of the members and trustees of The Fraser Institute.



# Executive Summary

*Waiting Your Turn* presents the only comprehensive measure of hospital waiting lists across Canada. The survey measures the extent of health care rationing in the provinces from year to year. Information for the survey was provided by 2,197 specialists nationwide during the latter part of 1998.

This year’s survey results show that more Canadians were waiting to receive medical treatment in 1998 than in 1997. According to the study, 212,990 Canadians were waiting for surgical procedures, an increase from the 1997 estimate of 187,799. Not only were there approximately 13 percent more people waiting for treatment than there were in 1997 but those waiting were waiting longer to receive their treatment—13.3 weeks between referral to a specialist by a general practitioner (GP) and the receipt of treatment. In 1997, they were waiting 11.9 weeks. The total waiting time for Canadians to receive treatment in 1993 was 9.3 weeks (graphs 5 and 6; graphs are found on pages 19 to 26).

## GP to specialist

The first of the two components of waiting time is the time between the patient’s visit to the GP and the patient’s visit to a specialist. This waiting time for consultation with a specialist is shown in table 2 and chart 2 (tables are found on pages 27 to 54, charts on pages 8 to 18). Most waits for specialist appointments were less than two months. However, there were a number of instances in which the measured wait was three months or longer. British Columbia had the shortest wait in the country for specialist consultations, while Prince Edward Island had the longest. In only two provinces—Quebec and Newfoundland—did waiting time to see a specialist decrease compared to 1997. For Canada as a whole, the waiting time to see a specialist increased by 17.6 percent from 1997 to 1998 (from 5.1 to 6.0 weeks), and by 62.2 percent since 1993, when it was 3.7 weeks (graphs 1 and 2). Obviously, patients who are unable to see a specialist are effectively screened from receiving treatment. This form of health care rationing is increasingly occurring in Canada.

As evidence of this, a recent national survey by the College of Family Physicians of Canada (1996) found that between 70 and 80 percent of family physicians were having to spend more time arranging for their patients to receive care than they had five years previously because of growing waiting times to see a specialist, gain admission to a hospital, and receive diagnostic tests.

## Specialist to treatment

The second component of waiting time is the interval between the patient’s consultation with a specialist and treatment. For Canada as a whole, the wait for treatment after having seen a specialist increased from 6.8 weeks in 1997 to 7.3 weeks in 1998 (chart 3). In 1993, the wait for treatment after having seen a specialist was 5.6 weeks (graphs 3 and 4). This component of waiting varied substantially from province to province. In Saskatchewan—the province with the longest median waiting times for treatment after having seen a specialist—patients waited 14.7 weeks for surgical procedures, 9.5 weeks longer than people in Prince Edward Island, where the median wait for treatment was 5.2 weeks—the shortest provincial waiting time for treatment (table 28a).

## Total wait from GP to treatment

The “total” wait for treatment is the sum of the two components: the time between seeing a GP and seeing a specialist, added to the time between seeing a specialist and receiving treatment. In Canada as a whole, patients waited more than three months after seeing their GP before receiving treatment for their ailments. The total wait varied from 11.9 weeks in Ontario, Quebec, and Nova Scotia to 20.2 weeks in Saskatchewan (table 31 and chart 5). Across Canada, the longest waits for treatment tended to be for three specialties where the total wait a patient could expect to

face exceeded five months: orthopaedic surgery (25.4 weeks), ophthalmology (22.0 weeks), and elective cardiovascular surgery (20.2 weeks). The shortest wait among specialties was for cancer patients being treated with chemotherapy. These patients waited approximately 3.6 weeks to receive treatment.

### **Clinically reasonable waits from specialist to treatment**

The survey also measured what specialists consider to be clinically reasonable lengths of time to wait for surgical procedures. For Canada as a whole and across all specialties, estimated reasonable waiting time increased slightly from 4.2 weeks in 1997 to 4.3 weeks in 1998. In 1994, the amount of time specialists thought to be a clinically reasonable wait between specialist and treatment was 5.2 weeks (graphs 7 and 8). Chart 4 compares the actual median waiting times to the clinically reasonable median waiting times for the different specialties. The largest gap between actual and reasonable waiting times was for elective cardiovascular surgery, where the actual waiting time was 8.1 weeks longer than what is considered to be reasonable by specialists. The comparison of actual waits with clinically acceptable waits in table 45

shows that in most specialties in most provinces, specialist physicians believe that Canadians have to wait longer for care than is healthy.

### **The wait for diagnostic testing**

The growing wait to see a specialist and to receive treatment are not the only delays that patients faced. Patients also experienced an increase in the waiting times for various diagnostic technologies across Canada: computerized tomography (CT) scans, magnetic resonance imaging (MRI), and ultrasound (chart 8). The median wait for a CT scan across Canada was 4.7 weeks, a 14.6 percent increase over 1997. The longest wait for computerized tomography was found in Prince Edward Island (7.1 weeks), while the shortest wait occurred in Nova Scotia (3.4 weeks). The median wait for an MRI across Canada was 11.4 weeks, an 18.8 percent increase in waiting time since 1997. Patients in Prince Edward Island experienced the shortest wait for an MRI (.7 weeks), while Alberta residents waited longest (17 weeks). Finally, the median wait for ultrasound was 2.9 weeks across Canada, an 11.5 percent increase over 1997. Ontario displayed the shortest wait for ultrasound (1.7 weeks), while Manitoba exhibited ultrasound waiting of 8.8 weeks.



# Waiting Your Turn

## Introduction

*With 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.*

McDonald, Shortt, Sanmartin,  
Barer, Lewis, and Sheps 1998

Waiting list measurement is an enterprise fraught with criticism. Yet, despite the vigorous disclaimers expressed in government-contracted reports such as the National Health Research and Development Program study quoted above, Canadian health care consumers are desperately concerned with waiting time and the general state of the health care system. Consequently, consumers, as well as health providers and policymakers, rely on available data regarding waiting time. Among these data, The Fraser Institute's annual study is the only comprehensive study of waiting across provinces and medical specialties. As such, *Waiting Your Turn* may be particularly subject to attack because of its very prominence in discussions of waiting time in particular and of health care reform in general. In this light, critiques by the federal and provincial governments are not surprising, in that the existence of lengthy waiting times is a potential indictment of government intervention in the medical system.

Indeed, governmental criticisms of early editions of *Waiting Your Turn* were common and fierce. At the time of this ninth edition, it appears, however, that imitation, albeit belated, is the sincerest form of flattery. Provincial health ministries are now more likely to monitor and collect waiting time data than ever before. A much-heralded example of this was the decision by British Columbia's Ministry of Health to disseminate on-line waiting-time information. The significance of waiting lists to the health policy debate was further signalled by federal Health Minister Allan Rock's \$2.2

million project to study waiting lists. Such governmental concern about waiting times is not only ironic because of previous criticisms but also because the existence of waiting lists for medical procedures and treatments is one manifestation of the governmental rationing of health sector resources that occurs in Canada. To the extent that there is rationing of hospital capacity by means other than price, monetary and non-monetary costs are nevertheless borne by Canadians, even though these costs are not explicitly recognized. These unrecognized costs may include, for example, lost work time, decreased productivity associated with physical impairment and anxiety, and physical and psychological pain and suffering.

A working person incapacitated by an illness bears the costs of the loss of work. These costs are not included among those associated with running the health care system. Cancer patients who must drive long distances to regional health centres or to the United States for radiation therapy bear costs in terms of lost time that are neither included in health costs nor in any way compensated by the health care system. A woman with a lump in her breast, who is told she must wait four weeks for a biopsy to determine whether the lump is cancerous, finds little comfort in the advice from her physician that epidemiological research shows that it does not matter to the outcome if the biopsy is delayed that long. The woman's anxiety and tangible psychological pain are not included in the costs of operating the health care system.

All of the foregoing represent actual cases in the Canadian health care experience and, in each of these cases, the savings to the government's budget are real but must be compared with the real though uncounted costs to Canadian health care consumers. While it is difficult to measure these costs, it is possible to measure the extent of queuing or the length of waiting lists in order to approximate the extent to which these costs may be mounting.

As noted, a number of health sector administrators are skeptical about the meaning and usefulness of waiting lists. They are skeptical both of the relevance of waiting lists

as an indicator of the performance of the health care sector, and of the reliability of such data as a measure of the extent of rationing of health care services (Amoko, Modrow, and Tan 1992). An earlier Fraser Institute publication evaluated various theoretical issues related to hospital waiting lists, including their relevance as measures of “excess demand” (Globerman 1990). This discussion defended the proposition that waiting lists are a potentially important barometer of performance in the health care sector. It also provided estimates of waiting lists for a set of hospital procedures in British Columbia. That study was followed in 1991 by a five-province analysis similar to the initial study. Since 1992, all 10 provinces in Canada have been surveyed.

This report builds upon the Institute’s earlier studies by updating waiting list estimates for all of the provinces. In the next section, the relevant theoretical issues are briefly reviewed.

### Waiting lists as measures of excess demand

One interpretation of hospital waiting lists is that they reflect excess demand for medical treatments performed in hospitals and that they therefore represent the substitution of “non-price” rationing of scarce resources for rationing by price. The rationing, in this case, takes place through enforced waiting for a given treatment or procedure. That such involuntary waiting is a form of rationing and not simply the postponement of a service can be seen from the fact that there are costs involved for those who are forced to wait. Data published in 1991 by Statistics Canada indicate that 45 percent of those who are waiting for health care in Canada describe themselves as being “in pain” (Statscan 1991). While not all of this pain would be alleviated by a visit to the doctor or by the surgical procedure for which the patient is waiting, some of it undoubtedly is the direct result of waiting. More recent Statistics Canada data show that over a million Canadians felt that they needed care but did not receive it in 1994, and that approximately 30 percent of these people were in moderate or severe pain (Statscan 1994/95).

A 1993 study by the Institute for Clinical Evaluative Studies at the University of Toronto categorized all patients waiting for hip replacements according to their pain levels (Williams and Naylor 1993). The study found that in Ontario 40 percent of those who were experiencing severe disability as well as 40 percent of those who suffered severe pain were waiting 13 months or more for hip surgery. A further 40 percent of those who were in severe pain waited seven to 12

months, while only 14 percent of those in severe pain waited less than four months. While some of these patients might have been postponing surgery for their own reasons, the fact that they were experiencing severe pain probably means that most were being denied prompt access to treatment.

To put the issue somewhat differently, consider wartime rationing of refrigerators or automobiles, which could simply be reinterpreted as imposed waiting. Those who wanted refrigerators in 1940 but did not get them until 1946 were not denied the refrigerators; they only had to wait. Obviously, however, the issue of time is important in goods provision. It is also important—in some cases crucial—in the provision of medical services.

Economists generally believe that non-price rationing of scarce resources is inefficient compared to rationing through the price system. In particular, prices are efficient mechanisms for signalling the relative scarcity and value of any good or service, thereby encouraging both producers and consumers to modify their behaviour accordingly. A rise in price occasioned by an increase in the demand for a particular medical procedure thus restrains some health care users, and effectively rations the existing supply. The price rise also sends out the signal that not enough health care is being supplied. Assuming that the price rise makes additional profits possible, there will be an increase in the supply of health care as suppliers change their behaviour to take advantage of the new possibility for profit. This supply response does not necessarily occur, however, if waiting is the system of rationing employed.

Non-price rationing is also inefficient because it obscures differences in intensities of demand across different sets of consumers. To the extent that some consumers desire a given product more than other consumers, strict non-price rationing might result in those consumers who desire the product *less* actually obtaining it. Efficiency, however, is promoted when those consumers who *most* value a product obtain it. For example, while a non-working spouse and his wife with the same medical condition might be equally restricted by a system of waiting lists, the working wife would probably be willing to pay a little more to be able to get back to work. The reason is that, in addition to the similar pain they both suffer, she also bears the additional cost of lost wages. With identical illnesses, the wife and husband do not have the same illness cost, including forgone wages, and thus place different values on the medical service that they are both denied by waiting.

At least two prominent qualifications can be raised about the social inefficiencies of rationing by waiting. One is the claim that, without rationing by waiting, many proce-

dures and treatments are performed for which the social costs outweigh the social benefits. Thus, making patients wait is efficient, the argument goes, so that they are prevented from using services for which social costs outweigh social benefits. In these cases, however, it would be more desirable to discourage the consumption of a given amount of medical services by price rationing rather than by non-price rationing. In other words, let the working wife pay the increased costs of earlier treatment so that she can get back to work and let her husband wait for an opening on the “elective” surgical waiting list. That is the appropriate approach unless one is prepared to argue that patients will pay any price to receive specific treatments (a view only supportable with regard to a few life-saving treatments) and that government bureaucrats are better able than consumers are to determine whether treatment is warranted.

A second qualification is that non-price rationing of a vital product such as medical services is fair and is perceived to be fair by society. To the extent that fairness is an objective, one might argue that non-price rationing provides collective benefits that outweigh the inefficiencies identified above. However, depending upon how the non-price rationing occurs, the resulting distribution of benefits may not be any improvement upon the price-rationing outcome. If, for example, in a rationing circumstance, personal acquaintance with the head of surgery, or social prominence, or wealth leads to less waiting (as found by Alter, Basinski, and Naylor 1998), then rationing by waiting simply becomes a facade for a system of personal privilege. Even if the probability of knowing the chief of surgery were not related to income, the replacement of rationing by price with rationing by acquaintance will only create a different form of unequal access. Moreover, perceived inequity in the distribution of medical services due to perceived inequity in income distribution can better be rectified by lump-sum income transfers or subsidies for the purchase of health insurance by the poor.

To be sure, there are many arguments that have been made both for and against private medical insurance systems (Blomqvist 1979; McArthur, Ramsay, and Walker 1996). For the purposes of this report, it is accepted that public provision of, and payment for, health care services is an institutionalized feature of Canadian society for the foreseeable future, and that extensive use of market pricing mechanisms to ration scarce capacity is unlikely. Under these circumstances, the extent of any excess demand and how that excess demand is rationed are relevant public policy issues, since the social costs associated with non-price rationing should be compared to whatever benefits are perceived to be associated with it.

## Non-price rationing and methods of adapting

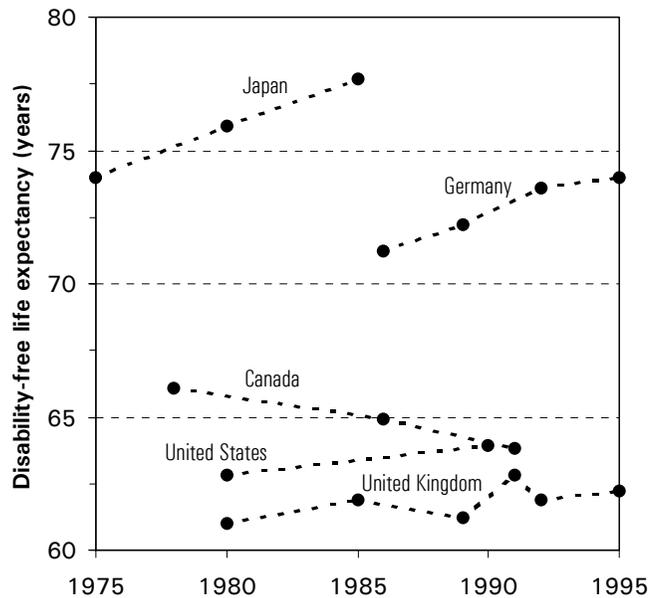
There are several ways in which non-price rationing can take place under the current health care system and many ways in which individuals adapt to rationing. One form of non-price rationing is a system of triage, the three-way classification system developed by Florence Nightingale for sorting the wounded on the battlefield in wartime. Under such a system, the physician sorts the patients into three groups: those who are beyond help, those who will benefit greatly from immediate care (and suffer greatly or die without it), and those who can wait for care.

In peacetime, of course, there still are limited resources, requiring physicians to employ the triage system to make choices about the order in which people should be treated. In this setting, physicians effectively ration access by implicitly or explicitly rejecting candidates for medical treatment. In the absence of well-defined criteria, doctors might be expected to reject those candidates least likely to suffer morbid consequences from non-treatment and those whose life expectancy would be least improved by treatment. The British experience suggests that some doctors use a foregone-present-value-of-earnings criterion for selecting patients for early treatment, thereby giving lower priority to older or incurable critically ill patients (see Aaron and Schwartz 1984). The experience of Canada’s largest cancer treatment centre suggests that doctors give priority for radiation treatment to people whose cancers may be curable rather than using the radiation machines to provide palliative care or limited extensions to life expectancy (*Globe and Mail* 1989: A1).

Although both men and women in Canada can expect to live, on average, about five years longer than they did 20 years ago, between 1978 and 1991 the number of years that Canadians could expect to live free of disabilities declined by 2.3 years for women (chart 1) and 0.4 years for men, while it was increasing during that time in most other OECD countries (OECD 1998). The reason for this decline is not obvious but it coincides with the findings of recent surveys that reveal an increasing degree of non-price rationing in the health care system in Canada. It has long been known that when non-price rationing emerges in a health care system, the elderly are the most likely to feel the impact (Binney and Estes 1988; McKinnon 1995; Agbayewa 1995) because, in a classic triage system, older patients tend to get placed at the end of the queue as they are expected to benefit less (receive shorter life extension, on average) from treatment.

Canadians may be adapting to non-price rationing by substituting private services for unavailable public services

**Chart 1: Disability-free life expectancy for women from selected OECD countries**



Source: *OECD Health Data 98*. Paris: OECD, 1998. Data available only for years shown.

and, specifically, by purchasing medical services outside the country. Provincial health care plans, in fact, cover emergency medical services as well as other services only available outside Canada. Possibly as a reflection of the increasing prevalence of waiting in the health care system, there are companies in Ontario and British Columbia that facilitate diagnostic testing and treatment in the United States (Taube 1999), and American medical centres have advertised in Canadian newspapers. This year's survey of specialists (reported later in this study) found that about one percent of patients inquired about treatment in another country.

## Measuring rationing by waiting

Observers who argue that hospital waiting lists are not a particularly important social issue believe that such lists tend to be inaccurate estimates of rationing or that there is little social cost associated with enforced waiting. One frequently expressed concern is that doctors encourage a greater demand for medical care than is socially optimal. As a result, the critics argue, while waiting lists exist for specific treatments, there are no significant social costs associated with rationing since many (perhaps most) individuals on waiting lists are not in legitimate need of medical treatment. In a related version of this argument, doctors are suspected of placing a substan-

tial number of patients on hospital waiting lists simply to exacerbate the public's perception of a health care crisis so as to increase public funding of the medical system.

The available evidence on the magnitude of the demand induced by the suppliers for medical services is, at best, ambiguous (see Frech 1996). The view that this is a modest problem is supported by the fundamental economic argument that competition among physicians will promote a concordance between the physician's interests and those of the patient. Effectively, general practitioners usually act as agents for patients in need of specialists while specialists carry out the bulk of hospital procedures. Thus, general practitioners who mitigate medical problems while sparing patients the pain and discomfort of hospital treatments will enhance their reputations compared to those who unnecessarily encourage short-term or long-term hospitalization as a cure. This suggests that general practitioners have an incentive to direct patients to specialists who will not overprescribe painful and time-consuming hospital treatments.

As well, specialists who place excessive numbers of patients on hospital waiting lists may bear direct costs. For example, those specialists may be perceived by hospital administrators to use a disproportionate share of hospital resources. This may make it more difficult for them to provide quick access to those resources for patients who, in their own view and those of their general practitioners, are in more obvious need of hospital treatment. Similarly, patients facing the prospect of a relatively long waiting list may seek treatment from other specialists with shorter waiting times.

An additional reason to be skeptical of claims that demand is induced by physicians is that it is implausible for an individual physician to believe that the length of his or her waiting list will significantly affect overall waiting time at the provincial or national level, thus leading to additional funding. Because this provides a clear incentive to "free-ride" on the potential wait-list-inflating responses of other physicians, there is no reason for any individual physician to inflate waiting times.

Finally, an additional concern in measuring waiting is that hospital waiting lists are biased upward because reporting authorities double-count or fail to remove patients who have either already received the treatment or who, for some reason, are no longer likely to require treatment. The survey results, however, indicate that doctors generally do not believe that their patients have been double-counted.

In summary, while there are hypothetical reasons to suspect that hospital waiting list figures might overstate true excess demand for hospital treatments, the magnitude of any resulting bias is unclear and probably relatively small.

## Hospital waiting list survey

In order to develop a more detailed understanding of the magnitude and nature of hospital waiting lists in Canada, the authors of this study conducted a survey of specialist physicians. Specialists rather than hospital administrators were surveyed because a substantial number of hospitals either do not collect waiting list data in a systematic manner or do not make such data publicly available (Amoko, Modrow, and Tan 1992: 36). In those instances where data from institutions are available, they have been used to corroborate the evidence from the survey data.

The survey was conducted in all ten Canadian provinces. Mailing lists for the specialists polled were provided by Cornerstone List Fulfillment. The specialists on these lists are drawn from the Canadian Medical Association's membership lists. Specialists were offered a chance to win a \$2,000 prize (to be randomly awarded) as an inducement to respond. Specialists rather than general practitioners were surveyed because specialists have primary responsibility for health care management of surgical candidates. Survey questionnaires were sent to practitioners of 12 different medical specialties: plastic surgery, gynaecology, ophthalmology, otolaryngology, general surgery, neurosurgery, orthopaedic surgery, cardiovascular surgery, urology, radiation oncology, medical oncology, and internal medicine. The original survey (1990) was pretested on a sample of individual specialists serving on the relevant specialty committees of the British Columbia Medical Association. In each subsequent edition of the survey, suggestions for improvement made by responding physicians have been incorporated into the questionnaires and, in 1994, radiation oncology and medical oncology were added to the ten specialties originally surveyed.

The questionnaire used for general surgery is included in the Appendix to this report. The questionnaires for all of the specialties follow this format; only the procedures surveyed differ across the various specialty questionnaires. The data for this issue of *Waiting Your Turn* were collected in December 1998.

For the most part, the survey was sent to all specialists in a category. In the case of internal medicine in Ontario, approximately 500 names were randomly selected. The response rate in the five provinces initially surveyed in 1990 (British Columbia, Manitoba, New Brunswick, Newfoundland, Nova Scotia) was 20 percent. This year, the response rate for these same provinces was 26 percent. The response

rate was 23 percent overall, which is quite high for a mailed survey but a decrease from the 26 percent response rate of last year's survey.

## Methodology

The treatments identified in all of the specialist tables represent a cross-section of common procedures carried out in each specialty. The original list of procedures was suggested by the specialty boards of the British Columbia Medical Association in 1990 and procedures have been added since then at the recommendation of survey participants.

At the suggestion of the Canadian Hospital Association, waiting time, since 1995, has been calculated as the median of physician responses rather than the mean or average, as it had been prior to 1995 (Canadian Hospital Association 1994). The disadvantage of using average waiting times is the presence of outliers (that is, specialists who report extremely long waiting times), which pull the average upwards. Changes in extreme outlier responses can have dramatic effects on the mean value even if the vast majority of the responses still cluster around the same median value. Using the median avoids this problem. The median is calculated by ranking specialists' responses in either ascending or descending order, and determining the middle value. For example, if five neurosurgeons in New Brunswick respond, the median value is the third highest (or third lowest) value among the five.<sup>1</sup> This means that if the median wait reported is 5 weeks for a procedure, half of the specialists reported waits of more than 5 weeks, while half of the specialists reported waits of less than 5 weeks.

The major findings from the survey responses are summarized in tables 2 through 45 (tables are found on pages 27 to 54). Table 2 reports the median time a patient waits for an appointment with a specialist after having been referred by a general practitioner. To obtain the provincial medians (and national median) found in the last row of table 2, the 12 specialty medians are each weighted by a ratio: the number of specialists of that type surveyed in the province divided by the number of specialists of all types surveyed in the province.

Tables 3 through 14 report the time a patient must wait for treatment after having seen a specialist, where the waiting time per patient is the median of the survey responses. The provincial weighted medians reported in the last line

(1) For an even-numbered group of respondents, say, 4 physicians, the median is the average of the two middle values—in this example, the average of the second and third highest values.

of each table are calculated by multiplying the median wait for each procedure (e.g., mammoplasty, neurolysis, etc. for plastic surgery) by a weight—the fraction of all surgeries within that specialty constituted by that procedure, with the sum of these multiplied terms forming the weighted median for that province and specialty.

Tables 15 through 26 report the estimated number of patients waiting for surgery. To allow for interprovincial comparisons, these tables also report the number of people waiting for surgery per 100,000 population. The number of people waiting for treatment is estimated using the average of the weeks waited for treatment as reported by responding specialists and Statistics Canada's *Hospital Morbidity and Surgical Procedures 1993/94* (Statscan 1994; more recent versions of this report are not yet available). This report provides a count of the total number of surgical procedures performed annually in each province. To estimate the number of individuals waiting for a particular surgery, the average weeks waited for a given operation is divided by 52 and then multiplied by the total number of persons annually undergoing this particular operation. This means that a waiting period of, say, one month implies that, on average, patients are waiting one-twelfth of a year for surgery. Therefore, the next person added to the list would find one-twelfth of a year's patients ahead of him or her in the queue. The main assumption underlying this estimate is that the number of surgeries performed will neither increase nor decrease within the year in response to waiting lists.

There are a number of minor problems in matching Statistics Canada's categories of operations to those reported in the survey. In several instances, an operation such as rhinoplasty is listed under more than one specialty. In these cases, the number of patients annually undergoing this type of operation is divided among specialties according to the proportion of that surgery performed in each specialty. A second problem is that, in some cases, an operation listed in the questionnaire has no match in the Statistics Canada report. An example is the urological operation called ureteral reimplantation for reflux, which is not listed in the Statistics Canada report. In these cases, no estimate is made of the number of patients waiting for these operations.

Tables 28a and 28b present, respectively, median waiting time and the estimated number of patients waiting, compared among specialties and provinces. Because the questionnaires omit some procedures that are less commonly performed, the estimate in table 28b of the number of people waiting is, of course, an underestimate of the total number waiting. Nevertheless, the lists of procedures surveyed in the questionnaires represent between 51 percent

and 66 percent of non-emergency surgery performed in each of the provinces studied.

The final row of table 28a displays the provincial and national weighted medians for the 12 specialties surveyed. As in table 2, weighted medians are calculated by multiplying the median wait for each specialty by the fraction of all surgeries in that province occurring in that specialty, and then summing these multiplied terms corresponding to each specialty.

The number of people waiting for non-emergency surgeries that were not included in the survey was also calculated, and is listed in table 28b as the "residual" number of patients waiting. To estimate the residual number of people waiting, the number of non-emergency operations done in each province annually that are not contained in the survey must be used. This residual number of operations (found in Statscan 1994) is then multiplied by each province's weighted average waiting time and divided by 52 (weeks). Estimates of the residual number of patients waiting are reported in table 28b.

Tables 32 through 43 report the median values for the number of weeks estimated by specialists to be clinically reasonable lengths of time to wait for treatment. The methodology used to construct these tables is analogous to that used in tables 3 through 14.

## Data verification with government, hospital, and other sources

In July 1999, all of the data were sent across Canada to provincial ministries of health, regional health authorities, and provincial cancer and cardiac agencies. Replies were received from provincial health ministries in Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland, Nova Scotia, Ontario, and Saskatchewan, from regional health authorities in Alberta (Capital Health Region), and New Brunswick (South-East Health Care Corporation), from cancer agencies in Alberta (Edmonton and Calgary), British Columbia, New Brunswick (Moncton), Nova Scotia, and Ontario, and from cardiac agencies in British Columbia (from its website), Ontario (from its website), and Quebec (Montreal).

The data provided allowed a number of direct comparisons to be made. In particular, 28 comparisons of waiting times were made, and 30 comparisons of numbers of people waiting were made. In 16 out of 28 waiting-time comparisons, the survey numbers were in excess of the provincially provided numbers while, in seven cases, the survey numbers understated the government-estimated waiting time, and, in five cases, were identical.

Of the 16 cases in which the survey data exceeded the government data, ten were data for British Columbia. In British Columbia, the Ministry of Health defines waiting time in a manner that, by necessity, make its estimates smaller than those in this survey. Specifically, the Ministry defines a wait as the interval between the time the procedure is formally scheduled and the time it is actually carried out. Not only does this definition omit waiting time between GP and specialist (which the Institute's survey includes in the total), but it understates the patient's actual waiting time between seeing a specialist and actually receiving treatment. Nevertheless, the Ministry suggests that the degree of understatement is small: "We believe that in most cases surgeons forward . . . booking forms without delay once a decision to perform the procedure is taken, and that hospitals receive them within a day or two" (Kelly 1999). However, because most hospitals only book a few months ahead, this method of measuring waiting lists undoubtedly omits a substantial fraction of patients with waits beyond the booking period (see Ramsay 1998).

If the discrepancies between the survey and the data from British Columbia are ignored due to this difference in definitions, there are six remaining cases in which the survey data exceeds government estimates, seven cases in which the government data exceeds the survey data, and five cases in which they are identical. This approximate equality in the number of overstatements and understatements suggests that any errors in the survey data are not biased in either direction.

Finally, of the 30 cases in which numbers of patients waiting were compared, the estimates from this survey were exceeded by the government estimates in 25 cases. In other words, governments, in most cases, reckoned that more people were waiting than participants in the Institute's survey did.

## Comparing other waiting list studies

A few previous assessments of waiting lists in particular provinces have been produced. In 1967, a survey of British Columbia hospitals was done by the British Columbia Hospital Insurance Service (Pallan 1967). This study estimated that in 1967 the total number of people on hospital waiting lists in British Columbia exceeded 12,000—0.6 percent of the population in British Columbia that year. The 1998 estimate of 35,385 people waiting for surgery in British Columbia (an increase of 6,924 from the 1997 estimate) represents 0.9 percent of the 1998 population.

A brief survey of Ontario hospitals undertaken in October 1990 for the General Accounting Office of the United States Government (1991) suggests that patients waiting for elective orthopaedic surgery were waiting from 8.5 weeks to 51 weeks, that elective cardiovascular patients were waiting one to 25 weeks, and that elective ophthalmology patients were waiting 4.3 to 51 weeks. The new survey data presented here finds typical Ontario patients waiting 12.4 weeks for orthopaedic surgery, 16.3 weeks for elective cardiovascular surgery, and 10.9 weeks for ophthalmology procedures in 1998.

A study of waiting times for radiotherapy in Ontario (Mackillop *et al.* 1993) found that the median waiting times between diagnosis by a GP and initiation of radiotherapy for carcinoma of the larynx, carcinoma of the cervix, and non-small-cell lung cancer were 30.3 days, 27.2 days, and 27.3 days, respectively. The new survey data for 1998 fall within two weeks of these estimates. In Ontario in 1998, the wait for radiotherapy was 37.1 days for larynx cancer, 38.5 days for cervix cancer, and 42 days for lung cancer (waiting times from referral, to meeting with a specialist, to treatment). However, the 1998 estimate that the median wait for prostate cancer treatment was 59.5 days is much lower than Mackillop's estimate of 93.3 days.

An international study of waiting times for selected cardiovascular procedures found that in Canada 13.3 percent of waiting times for elective coronary bypass surgery fell in the two-to-six-week range, with 40 percent in the six-to-12-week range, 40 percent in the 12-to-24-week range, and 6.7 percent in the over-36-weeks range (Carroll *et al.* 1995). For all of the heart procedures surveyed, the waiting times were longer in Canada, Sweden, and the United Kingdom than in the United States. The 1998 data presented here, by comparison, indicated that the provincial waiting time for elective bypass surgery ranged from eight weeks in Manitoba to 52 weeks in Newfoundland. Overall, the waiting time for elective cardiovascular surgery in Canada increased from 9.8 weeks in 1993 to 13.7 weeks in 1998 (graph 4; graphs are found on pages 19 to 26).

Lastly, a 1994 study on knee replacement surgery in Ontario found that the median wait for an initial appointment with an orthopaedic specialist was two weeks in the United States and four weeks in Ontario. The median waiting time to receive a knee operation was three weeks in the United States and eight weeks in Ontario (Coyte *et al.* 1994). The Institute's survey found that in Ontario in 1994 the wait to see an orthopaedic specialist was nine weeks and the wait to receive hip or knee surgery was 15 weeks. In 1998, these wait times had increased to 9.5 weeks and 16 weeks, respectively.

## Analysis of cardiovascular surgery

Cardiovascular disease is a degenerative process and the decline in the condition of a candidate for cardiac surgery is gradual. Under the Canadian system of non-price-rationed supply, some cardiac surgery candidates are displaced by patients with non-cardiac conditions that require immediate care. This is not a direct displacement but rather a reflection of the fact that hospital budgets are separated into sub-budgets for “conventional illness” and for other high-cost interventions such as cardiac bypass. Only a certain number of the latter are included in a hospital’s overall annual budget. Complicating matters is the ongoing debate about whether cardiac bypass surgery actually extends life. If it only improves the quality of life, it may be harder to justify increased funding.

The result has been lengthy waiting lists, often as long as a year or more, followed by public outcry, which in turn has prompted short-term funding. Across Canada, many governments have had to provide additional funding for heart surgery in their provinces. In the past, American hospitals have also provided a convenient short-term safety valve for burgeoning waiting lists for cardiac operations. The government of British Columbia contracted Washington state hospitals to perform some 200 operations in 1989 following public dismay over the six-month waiting list for cardiac bypass surgery in the province.

Wealthy individuals, furthermore, may avoid waiting by having heart surgery performed in the United States. A California heart-surgery centre has even advertised its services in a Vancouver newspaper. This year’s survey suggests that while very few British Columbians with heart disease (one percent) inquired about the possibility of treatment outside the country in 1998, five percent of them did inquire about treatment outside of the province. Residents of Saskatchewan, however, made interprovincial inquiries much more frequently (20 percent) and ten percent received cardiac surgery outside the province; the latter figure was matched by residents of Newfoundland. For Canada as a whole, one percent of cardiac patients inquired about surgery outside of the country.

Excess demand and limited supply have led to the development of a fairly stringent system for setting priorities in some hospitals. In some provinces, patients scheduled for cardiovascular surgery are classified by the urgency of their medical conditions. In these cases, the amount of time they wait for surgery will depend upon their classifications. Priorities are usually set based on the amount of pain (*angina pectoris*) that patients are experiencing, the amount of

bloodflow through their arteries (usually determined by an angiogram test), and the general condition of their hearts.

Since 1993, the cardiovascular surgery questionnaire, following the traditional classification by which patients are prioritized, has distinguished among emergent, urgent, and elective patients. However, in discussing the situation with physicians and hospital administrators, it became clear that these classifications are not standardized across provinces. British Columbia and Ontario use a nine-level prioritization system developed in Ontario. Other provinces have a four-level system, with two urgent classifications. Decisions as to how to group patients were thus left to responding physicians and heart centres. Direct comparisons among provinces should, therefore, be made tentatively, while recognizing that this survey provides the only comparative data available on the topic.

As noted earlier in the text, efforts were made again this year to verify the cardiovascular surgery survey results, using hospital statistics, data from provincial health ministries, and data from provincial cardiac agencies in British Columbia (from its website), Ontario (from its website), and Quebec (Montreal). Where these data have been used in the tables, a note has been made.

Estimates of the length of cardiac waiting lists were either taken directly from this information, or were extrapolated from the survey results. The survey estimates of the numbers of people waiting for heart surgery were derived in the same manner as those for the other specialties, using average waiting time for urgent patients. The average waiting time for urgent patients was used instead of the emergent or elective wait times because it is the intermediate of the three measures. In provinces where the length of the waiting list was provided by the hospitals, it became clear that the average wait for elective surgery overestimated the length of the line, while the emergent average waiting time underestimated it.

In 1991, an Ontario panel of 16 cardiovascular surgeons attempted to outline explicit criteria for prioritizing patients (Naylor *et al.* 1991). The panel also suggested intervals that were safe waiting times for coronary surgery candidates. This process generated nine categories of treatment priority. For comparative purposes, it was necessary to collapse their nine priority categories down to the three used in this study. Once this was done, their findings suggested that emergent patients should be operated on within three days (0.43 of a week). Two of the seven provincial median emergent wait times for coronary artery bypass in this year’s survey fall outside of this range. However, physicians in these provinces may define “emergent” to include patients

that might be considered “urgent” in other provinces. According to the Ontario panel, urgent surgeries should be performed within six weeks. By comparison, the median wait for urgent cardiac surgery in British Columbia falls outside of this range, and is equal to that number in Manitoba. Finally, the Ontario panel suggests that elective surgeries be performed within a period of six months. Only Newfoundland currently falls outside of this time frame.

In past years (except for 1998), the Ontario panel's waiting-time estimates were used as the measure of the clinically reasonable wait for patients requiring cardiovascular surgery. However, this year (as in 1998), cardiovascular surgeons were asked to indicate their impression of the clinically reasonable length of time for their patients to wait. This year's survey found specialists to be much less tolerant of long waits than the Ontario panel. This year's respondents felt that urgent patients should only wait 0.9 weeks for surgery (instead of six weeks), and that patients requiring elective cardiovascular surgery should only wait 5.6 weeks (instead of 24 weeks).

## Survey results: estimated waiting in Canada

### Waiting for an appointment with a specialist

Table 2 indicates the median number of weeks that patients wait for initial appointments with specialists after referral from their general practitioners or from other specialists. Most waits for specialists' appointments are less than two months in duration. However, there are a number of waiting times of three months or longer: to see a plastic surgeon in Alberta, Manitoba, Newfoundland, or Nova Scotia; to see an ophthalmologist in Ontario, Nova Scotia, or Prince Edward Island; to see an otolaryngologist in Alberta; to see a neurosurgeon in Alberta, Saskatchewan, or New Brunswick; to see an orthopaedic surgeon in Alberta or Newfoundland; and to see a cardiovascular surgeon in New Brunswick. The weighted medians, depicted in chart 2, reveal that British Columbia has the shortest wait in the country for appointments with specialists while Prince Edward Island has the longest. In most provinces,

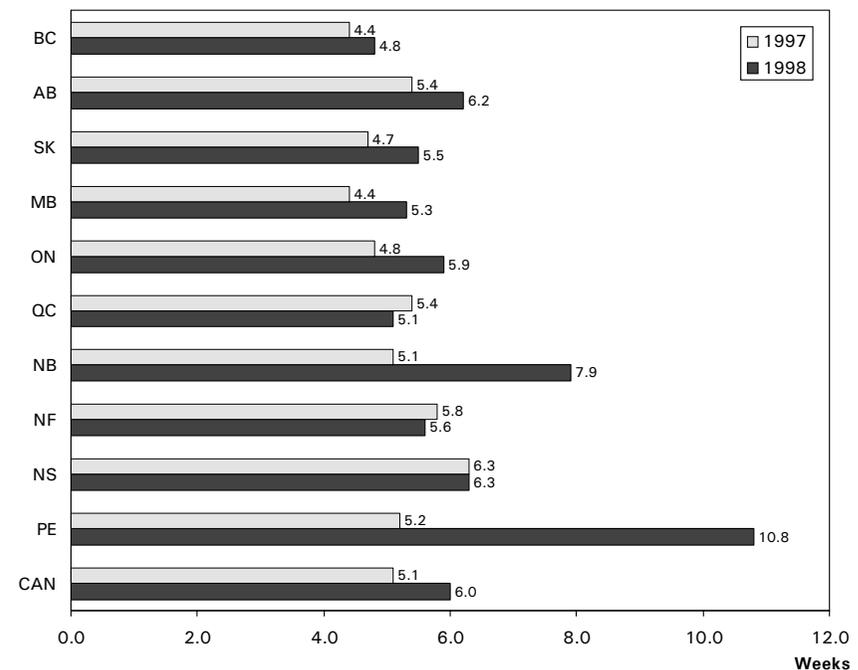
the waiting time to see a specialist has increased since 1997. For Canada as a whole, the waiting time to see a specialist increased by 17.6 percent from 1997 to 1998, and by 62.2 percent since 1993 (graphs 1 and 2).

### Time spent waiting for treatment

Several general observations can be made about tables 3 through 14 and tables 32 through 43. Residents of all provinces surveyed are waiting significant periods of time for hospital treatments. While some treatments have short waits, most procedures require waits of at least a month. Eighty-five percent of the actual weighted median waiting times are greater than the clinically reasonable weighted median waiting times. For example, the median wait for radiation oncology in British Columbia is 9.5 weeks. A clinically reasonable length of time to wait, according to specialists in British Columbia, is about 2.8 weeks. In Newfoundland, the actual time to wait for an otolaryngology procedure is 29.9 weeks, whereas a wait of four weeks is considered to be clinically reasonable. The differences between the median reasonable and median actual waits for the specialties are summarized in table 45.

Ranking the provinces according to the weighted medians reported in table 28a indicates that the longest median wait for surgery after visiting a specialist occurs in Saskatchewan and the shortest is found in Prince Edward Is-

**Chart 2: Waiting by province in 1997 and 1998: weeks waited from referral by GP to appointment with specialist**



Source: The Fraser Institute, annual waiting list survey, 1998 and 1999.

land. There is a 9.5-week difference between these shortest and longest weighted medians. The median waits for treatment by province are illustrated in chart 3. For Canada as a whole, the wait for treatment after having seen a specialist increased from 6.8 weeks in 1997 to 7.3 weeks in 1998. In 1993, the wait for treatment after having seen a specialist was 5.6 weeks (graphs 3 and 4).

Tables 30a and 30b present a frequency distribution of the median waits for surgery by province and by region. In all provinces, the majority of operations have waiting lists of less than three months. Saskatchewan has the smallest proportion of waits under three months, and the Prairie provinces have the greatest proportion of median waiting times over six months. In contrast, 90.3 percent of Ontario's median waits are under three months long, and only 1.1 percent are over six months, a figure matched by Quebec.

**Number of people waiting for treatment**

Numbers of people waiting are enumerated in tables 15 through 26. Because provincial populations vary greatly, it is hard to gauge the differences in the lengths of waiting lists solely on the basis of the sheer numbers of people waiting. For example, in Ontario, there are 1,131 people waiting for plastic surgery, while there are only 250 waiting in Manitoba. However, more people are waiting per 100,000 population in

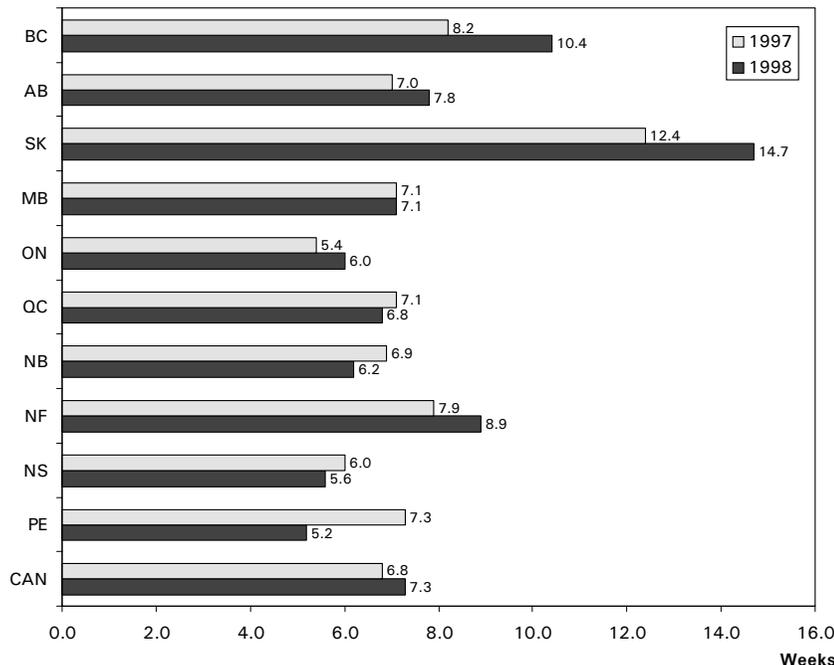
Manitoba: 22 people per 100,000 population are waiting in Manitoba, while only 10 people per 100,000 are waiting in Ontario. Table 27 provides a summary of the waiting numbers statistics.

**Comparison of specialist-to-treatment wait and numbers waiting between 1997 and 1998**

This year's study indicates an overall increase in the waiting time between consultation with a specialist and treatment for British Columbia, Alberta, Saskatchewan, Ontario, and Newfoundland (table 29a; chart 3). Prince Edward Island displays the greatest improvement in waiting times from specialist to treatment. Meanwhile, from 1997 to 1998 the median wait increased by 27 percent in British Columbia and 19 percent in Saskatchewan.

Most provinces experienced an increase in the number of people waiting as well (table 29b). The only provinces that show fewer people waiting for surgery are New Brunswick and Prince Edward Island. The number of people waiting for surgery in Canada increased from 187,799 in 1997 to 212,990 in 1998. Throughout Canada, there are 13 percent more people waiting for surgery, and they are waiting 7.4 percent longer between consultation with a specialist and treatment, compared to 1997.

**Chart 3: Waiting by province in 1997 and 1998: weeks waited from appointment with specialist to treatment**



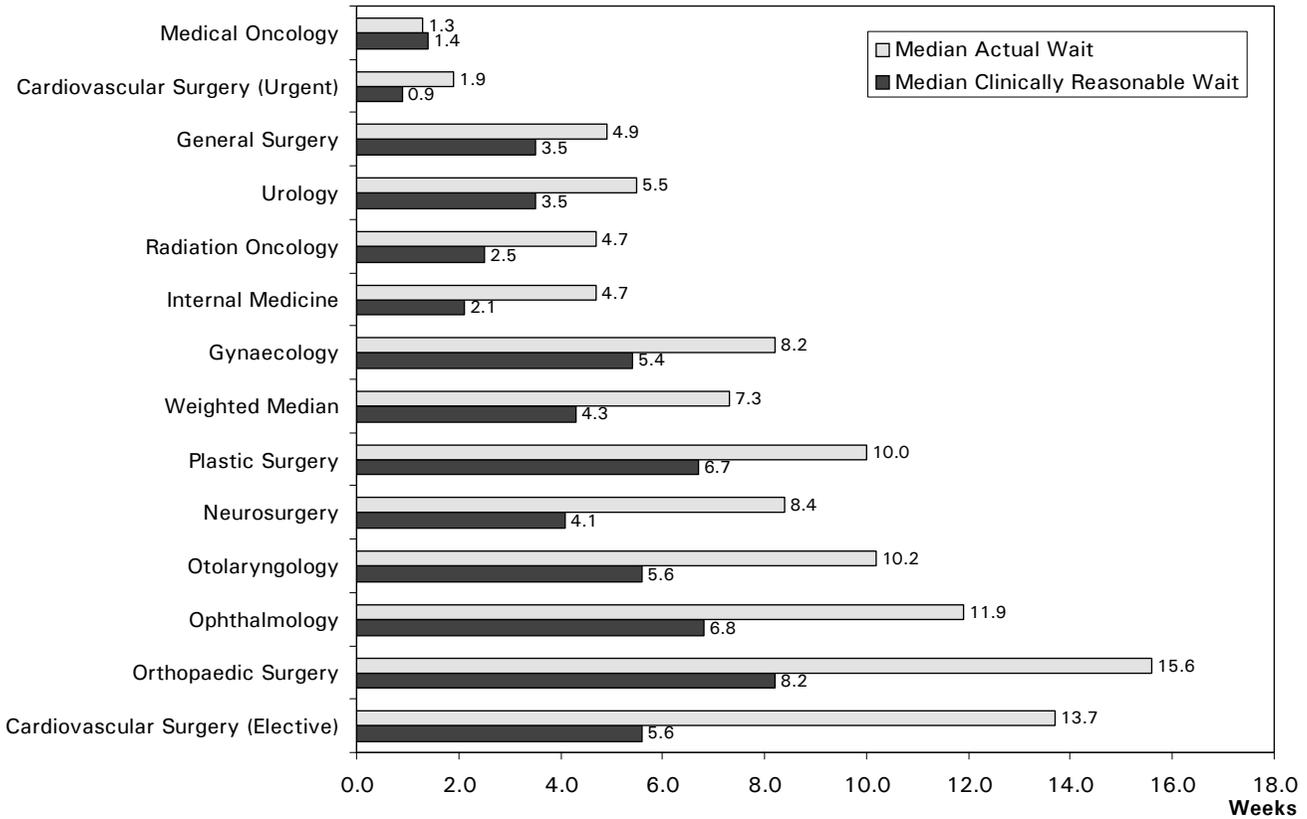
Source: The Fraser Institute, annual waiting list survey, 1998 and 1999.

**Clinically reasonable waiting times**

When asked to indicate a clinically reasonable waiting time for the various procedures, specialists generally indicated a period of time substantially shorter than the median number of weeks patients were actually waiting for treatment. Table 44 summarizes the weighted median reasonable waiting times for all specialties surveyed. These weighted medians were calculated in the same manner as those in table 28a.

Chart 4 compares the actual median number of weeks patients are waiting for treatment in Canada after having seen a specialist with the reasonable median number of weeks specialists feel patients should be waiting. The largest difference between these two values is in elective cardiovascular surgery, where the actual waiting time is 8.1 weeks longer than what is considered to be reasonable by specialists.

**Chart 4: Actual versus clinically reasonable wait by specialty for Canada: weeks waited from appointment with specialist to treatment in 1998**



Source: The Fraser Institute, annual waiting list survey, 1999.

**Estimated total waiting time in Canada**

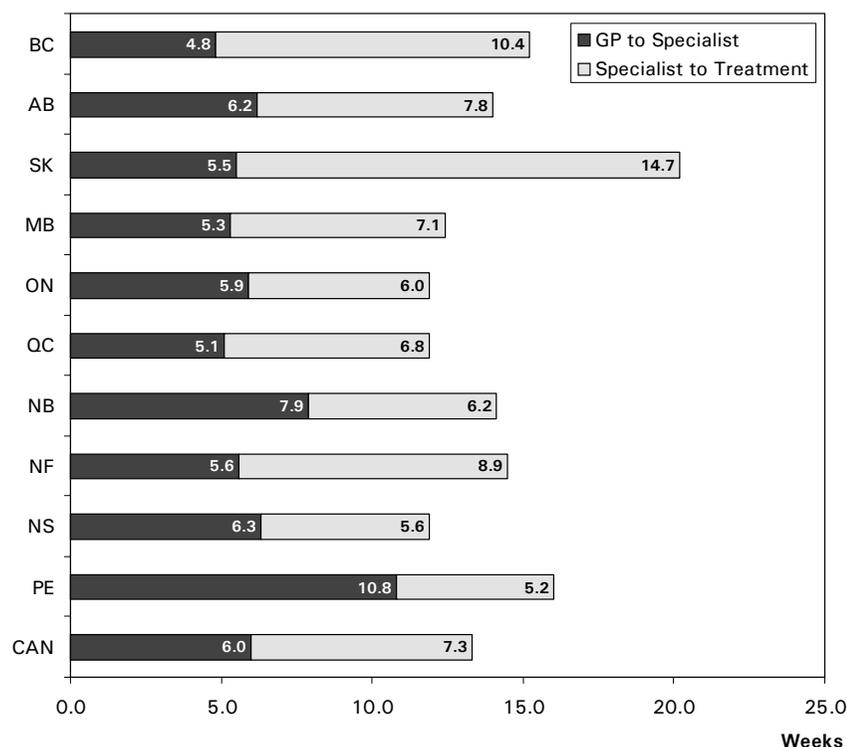
While waiting times for surgery after a visit to a specialist convey a mixed impression about the apparent extent of health care rationing, there is much less ambiguity when the overall wait for health care is considered. This overall wait, which records the time between the referral by a general practitioner to the time that the required surgery is performed, includes an additional wait for the appointment to see the specialist. Table 31 and chart 5 present the combined waiting times. They indicate that patients wait more than two months for relief of their ailments, from a weighted median of 11.9 weeks in Ontario, Quebec, and Nova Scotia to 20.2 weeks in Saskatchewan.

For Canada as a whole, the longest waits for treatment are in orthopaedic surgery, ophthalmology, elective cardiovascular surgery, and neurosurgery. The median waits for these specialties (chart 6) are 4 months or longer: 25.4 weeks for orthopaedic surgery, 22 weeks for ophthalmology, 20.2 weeks for elective cardiovascular surgery, and

18.6 weeks for neurosurgery. The shortest wait in Canada is for cancer patients being treated with chemotherapy. These patients wait approximately 3.6 weeks to receive their treatment.

**Health expenditures and waiting times**

Given the variation in waiting time across the provinces, a natural question is whether those provinces with shorter waiting times achieve this result by spending more on health care. To evaluate this hypothesis, provincial weighted medians (i.e., the last line in table 31) for the years from 1994 to 1997 were taken from the previous four editions of *Waiting Your Turn*. The statistical technique of regression analysis was used to assess whether provinces that spent more on health care (controlling for age differences across provinces) had shorter waiting times. The measure of spending used was real (i.e., inflation-adjusted) per-capita total spending on health care. The analysis revealed that provinces that spent more on health care per person, adjusted for inflation, had

**Chart 5: Total wait by province in 1998: weeks waited from referral by GP to treatment**

Source: The Fraser Institute, annual waiting list survey, 1999

neither shorter nor longer weighted median waiting times than provinces that spent less.<sup>2</sup>

This finding, that additional spending has no effect on waiting, while surprising at first, becomes more understandable when one considers the environment in which Canadian health care is provided. Canadian health care is an enterprise highly dominated by government. Indeed, in 1997, the fraction of total Canadian health spending attributable to governments was 69 percent, and this figure was even higher in preceding years (reaching 77 percent as recently as 1983). A substantial body of economic research demonstrates that governments are almost always less effective providers of goods and services than private firms. Mueller's (1989) comprehensive analysis of 50 studies comparing government and private provision of a variety of goods and services discovered that government provision was superior to private provision (in terms of higher productivity and lower costs) in only two out of those 50 cases. Consequently, the revelation that higher spending appears to elicit no improvement in waiting

time is entirely consistent with this literature. Ominously, this implies that, given the health system's current configuration, increases in spending should not be expected to shorten waiting times.

## A note on technology

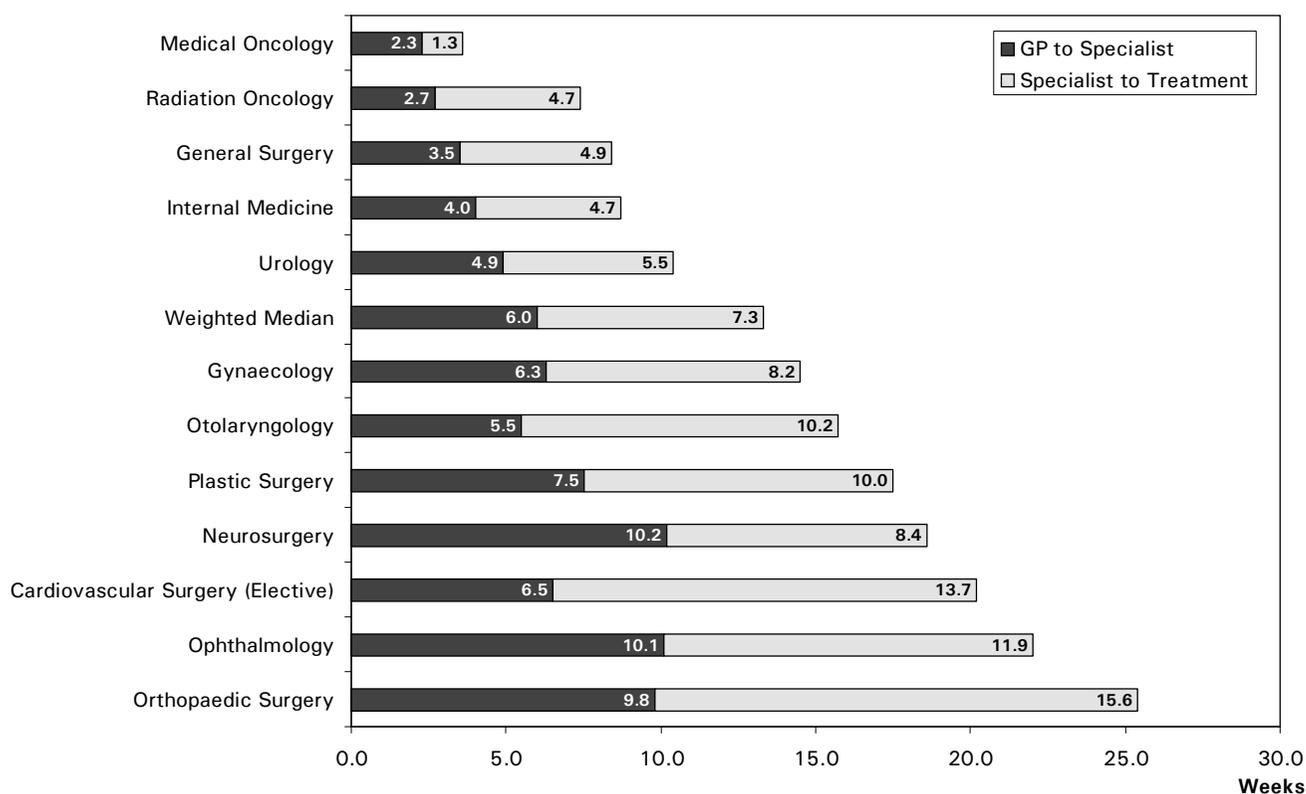
The wait to see a specialist and the wait to receive treatment are not the only waits that patients face. Within hospitals, limited budgets force specialists to work with scarce resources. Chart 7 gives an indication of the difficulties that Canadian patients have in gaining access to modern medical technologies, compared to their counterparts in the rest of the Organisation for Economic Cooperation and Development (OECD). Despite the fact that Canada is the fifth-highest spender on health care (as a percentage of GDP) in the OECD, the availability of medical technology (per million people) in Canada typically ranks in the bottom

third of OECD nations. Specifically, Canada exhibits low availability of computed tomography (CT) scanners, lithotriptors (which break up kidney stones), and magnetic resonance imagers (MRIs), with only radiation equipment in relative abundance (Harriman, McArthur, and Zelder 1999).

There are, of course, differences in access to technology among the provinces. This year's study examined the wait for various diagnostic technologies across Canada. Chart 8 displays the median number of weeks patients must wait for access to a CT scanner, an MRI, or an ultrasound machine. The median wait for a CT scan across Canada was 4.7 weeks, a 14.6 percent increase over 1997. The longest wait for computerized tomography was found in Prince Edward Island (7.1 weeks), while the shortest wait occurred in Nova Scotia (3.4 weeks). The median wait for an MRI across Canada was 11.4 weeks, an 18.8 percent increase in waiting time since 1997. Prince Edward Island patients experienced the shortest wait for an MRI (.7 weeks), while Alberta residents waited longest (17 weeks). Finally, the median wait for ultra-

(2) This conclusion also held when the spending measure used was per-capita, inflation-adjusted government spending on health care. In this case, however, the effect of spending on waiting more closely approached statistical significance than in the case where total (government plus private) per-capita spending was used. Even if this statistically insignificant effect were taken seriously, it is small in size. Specifically, it indicates that the federal government's \$2 billion increase in CHST payments in the 1999 Budget, if it were all devoted to health spending (which is unlikely), would only reduce waiting time by 2 days!

Chart 6: Total wait by specialty in 1998: weeks waited from referral by GP to treatment



Source: The Fraser Institute, annual waiting list survey, 1999.

Chart 7: Canadian Medical Technology and Health Spending Relative to the OECD, 1997<sup>a</sup>

Technology	Canadian Value <sup>b</sup>	OECD Average <sup>b</sup>	Canadian Rank	Sample Size
CT Scanners	8.1	12.9	21	28
Radiation Equipment	5.3	4.2	6	17
Lithotriptors	0.4	1.4	19	22
MRIs	1.7	3.9	19	27
National Health Expenditure	9.3% of GDP	7.7% of GDP	5	29

<sup>a</sup> Not all countries reported 1997 figures for all categories.

<sup>b</sup> Number per million population, except where noted (last row of table).

Source: from Harriman, McArthur, and Zelder 1999: 9; *OECD Health Data 98*. Paris: OECD, 1998.

Chart 8: Waiting for technology; weeks waited to receive selected diagnostic tests in 1997 and 1998

	Computerized Tomography		Magnetic Resonance Imaging		Ultrasound	
	1998	1997	1998	1997	1998	1997
British Columbia	5.9	5.3	12.3	10.5	2.3	1.9
Alberta	6.1	3.7	17.0	8.6	2.4	1.6
Saskatchewan	4.9	4.6	16.6	13.9	4.0	2.2
Manitoba	5.9	6.5	16.8	10.1	8.8	8.8
Ontario	4.4	3.8	11.0	10.6	1.7	1.5
Quebec	4.2	3.6	9.1	8.6	3.8	3.6
New Brunswick	3.8	3.7	8.3	7.3	4.0	4.5
Newfoundland	6.4	5.6	11.5	8.0	3.8	4.8
Nova Scotia	3.4	3.0	7.3	5.4	2.4	2.1
Prince Edward Island	7.1	5.7	0.7	2.2	4.6	3.6
Canada	4.7	4.1	11.4	9.6	2.9	2.6

Source: The Fraser Institute, annual waiting list survey, 1998 and 1999.

sound was 2.9 weeks across Canada, an 11.5 percent increase over 1997. Ontario displayed the shortest wait for ultrasound (1.7 weeks) while Manitoba exhibited ultrasound waiting of 8.8 weeks.

## Conclusion

The 1999 *Waiting Your Turn* survey indicates that the waiting list situation has deteriorated since 1998: waiting for health services in Canada is a reality and a growing problem. Even if one debates the reliability of waiting-list data, this survey reveals that specialists feel their patients are waiting too long to receive treatment. Furthermore, a 1996 national survey conducted by the College of Family Physicians of Canada showed that general practitioners were also concerned about the effects of waiting on the health of their patients (College of Family Physicians of Canada 1996). Almost 70 percent of family physicians felt that the waiting times being experienced by their patients were not acceptable.

Patients would also prefer earlier treatment, according to this year's survey data. On average, in all specialties, only 5.6 percent of patients are on waiting lists because they

requested a delay or postponement of their treatment. The responses range from a low of 2.6 percent of internal medicine patients requesting a delay of treatment, to a high of 7.3 percent of orthopaedic patients requesting a delay of treatment. Conversely, the percentage of patients who would have their surgeries within the week if there were an operating room available is greater than 50 percent in all specialties except gynaecology and plastic surgery. Radiation oncology patients are the most anxious to receive treatment, with 88.9 percent of patients willing to receive their treatment within the week. Internal medicine patients are the next most anxious: 88 percent of these patients were willing to have their surgery or treatment within the week.

Yet, the disturbing trend of growing waiting times in most provinces, documented here, implies that these expectant patients are increasingly likely to be disappointed. Even more discouraging is the evidence presented here that provinces that spend more on health care are not rewarded with shorter waiting lists. This means that under the current regime—first-dollar coverage with use limited by waiting—prospects for improvement are dim. Only substantial reform of that regime is likely to alleviate the medical system's most curable disease—protracted waiting for care.