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About the Authors

Nadeem Esmail is Senior Health Policy Analyst and Manager of Health Data Systems at The Fraser Institute. He completed his BA (Honours) in Economics at the University of Calgary, and received an MA in Economics from the University of British Columbia. His recent publications and co-publications for The Fraser Institute include *Waiting Your Turn: Hospital Waiting Lists in Canada*, 14th Edition (2004), *How Good Is Canadian Health Care? 2005 Report* (2005), and *The Alberta Health Care Advantage: An Accessible, High Quality, and Sustainable System* (2004). His articles have appeared in newspapers across Canada and he has been a guest on numerous radio and TV programs across the country.

Michael Walker directed the activities of The Fraser Institute from 1974 to 2005. Before that, he taught at the University of Western Ontario and Carleton University and was employed at the Bank of Canada and the Federal Department of Finance. He received his PhD at the University of Western Ontario and his BA at St. Francis Xavier University. He has written or edited 48 books on economic topics. His articles on technical economic subjects have appeared in professional journals in Canada, the United States, and Europe, including the *Canadian Journal of Economics*, the *American Economic Review*, *The Journal of Finance*, the *Canadian Tax Journal*, *Health Management Quarterly*, and *Health Affairs*. He is a director of a number of firms and other enterprises, including Mancal Corporation and the Milton and Rose D. Friedman Foundation. In 1992, he was awarded the Colin M. Brown Freedom Medal by the National Citizens Coalition and in 2003 an honorary Doctor of Laws degree by the University of Western Ontario.

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Preface

This *Critical Issues Bulletin* is the Institute's fifteenth 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.

At that time, 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 and more complete than in years past, they are still incomplete in many provinces and not generally comparable between provinces, meaning that there are no comprehensive measures other than those produced by The Fraser Institute by which to measure the length of waiting lists across Canada.

The contents of the survey have been evaluated to the extent possible by comparing the survey results 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, as well as to provincial cardiac and cancer agencies.

Measurement is crucial to understanding how any system works; where a system contains 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 Canadian policy makers continue to consider the implications of queuing on a medical level, and give much more thought to the implications of queuing at the personal level, as they design alternatives to our present health care arrangements.

While this study and its widespread distribution have 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

The Fraser Institute's fifteenth annual waiting list survey found that Canada-wide waiting times for surgical and other therapeutic treatments fell slightly in 2005, making this the first reduction in the total wait for treatment measured in Canada since 1993. Total waiting time between referral from a general practitioner and treatment, averaged across all 12 specialties and 10 provinces surveyed, fell from 17.9 weeks in 2004 back to the 17.7 weeks last seen in 2003. This small nationwide improvement in access reflects waiting time decreases in 5 provinces, while concealing increases in waiting time in Manitoba, Ontario, New Brunswick, Nova Scotia, and Newfoundland.

Among the provinces, Ontario achieved the shortest total wait in 2005, 16.3 weeks, with Manitoba (16.6 weeks), and Alberta (16.8 weeks) next shortest. Saskatchewan, despite a dramatic 7.8 week reduction in the total wait time, exhibited the longest total wait, 25.5 weeks; the next longest waits were found in New Brunswick (24.5 weeks) and Newfoundland (22.3 weeks).

The first segment of waiting: between referral by general practitioner and visit to a specialist for consultation

The small drop in waiting time between 2004 and 2005 is the result of an decrease in both the first wait—the wait between visiting a general practitioner and attending a consultation with a specialist—and the wait between consultation with a specialist and actual treatment. The waiting time between referral by a GP and consultation with a specialist fell from 8.4 weeks in 2004 back to the 8.3 weeks seen in 2003. The shortest waits for specialist consultations were in Prince Edward Island (6.2 weeks), Manitoba (7.0 weeks), and British Columbia and Saskatchewan (7.2 weeks). The longest waits for specialist consultations occurred in Newfoundland (13.0 weeks), New Brunswick (12.9 weeks), and Nova Scotia (10.4 weeks).

The second segment of waiting: between the specialist's decision that treatment is required and treatment

Waiting time between specialist consultation and treatment—the second stage of waiting—fell from 9.5 weeks in 2004 to 9.4 weeks in 2005. Decreases in waiting times in British Columbia, Saskatchewan, Quebec, and Prince Edward Island were offset by increases in the six other provinces. The shortest specialist-to-treatment waits were found in Quebec (8.4 weeks), Alberta (8.6 weeks), and Ontario (8.7 weeks), while the longest such waits existed in Saskatchewan (18.3 weeks), New Brunswick (11.6 weeks), and British Columbia (11.2 weeks).

Waiting by specialty

Among the various specialties, the shortest total waits (i.e., between referral by a general practitioner (GP) and treatment) existed for medical oncology (5.5 weeks), radiation oncology (5.7 weeks), and elective cardiovascular surgery (8.3 weeks). Conversely, patients waited longest between a GP's referral and orthopaedic surgery (40.0 weeks), plastic surgery (36.2 weeks), and ophthalmology treatment (27.4 weeks). There was a large increase between 2004 and 2005 in the wait for orthopaedic surgery (+2.1 weeks), while wait times for General Surgery (+0.5 weeks) and Plastic Surgery (+0.4 weeks) increased slightly. These increases were offset by improvements for patients receiving treatment in neurosurgery (-3.9 weeks), elective cardiovascular surgery (-2.8 weeks), radiation oncology (-2.1 weeks), otolaryngology (-1.5 weeks), ophthalmology and urology (-1.3 weeks), internal medicine (-0.6 weeks), and medical oncology (-0.1 weeks).

Breaking waiting time down into its two components, there is also variation among specialties. With regard to GP-to-specialist waiting, the shortest waits are in radiation oncology (1.6 weeks), medical oncology (3.0

weeks), and cardiovascular surgery (3.1 weeks), while the longest waits are for plastic surgery (15.4 weeks), orthopaedic surgery (14.7 weeks), and ophthalmology (14.3 weeks). For specialist-to-treatment waiting, patients wait the shortest intervals for urgent cardiovascular surgery (1.1 weeks), medical oncology (2.6 weeks), and radiation oncology (4.1 weeks), and wait longest for orthopaedic surgery (25.3 weeks), plastic surgery (20.9 weeks), and ophthalmology (13.1 weeks).

Comparison between clinically “reasonable” and actual waiting times

In addition to actual waiting times for care, specialists are also surveyed as to what they regard as clinically “reasonable” waiting times. While these values by themselves do not reflect the state of actual waiting time, they can usefully be compared with actual waits to gain an understanding of the medical consequences of waiting for care in Canada. The comparison made is between reasonable and actual specialist-to-treatment waiting times for all 10 provinces and 13 specialties (both urgent and elective cardiovascular surgery are included); it reveals that out of the 123 categories (some comparisons were precluded by missing data), actual waiting time exceeded reasonable waiting time in 85 percent of the comparisons. Averaged across all specialties, Nova Scotia and Quebec came closest to meeting the standard of “reasonable,” in that their actual specialist-to-treatment waits only exceeded the corresponding “reasonable” values by 50 and 54 percent, respectively, smaller gaps than in the other provinces. This partially reflects higher standards as to what is “reasonable” in a number of other provinces, such as Ontario and Newfoundland.

Waiting for diagnostic and therapeutic technology

The growing waits to see a specialist and to receive treatment were not the only delays facing patients in 2005. Patients also experienced significant waiting times for various diagnostic technologies across Canada: computed tomography (CT), magnetic resonance imaging (MRI), and ultrasound scans. The median wait for a CT scan across Canada was 5.5 weeks. New Brun-

s-wick, Nova Scotia, and Prince Edward Island had the shortest wait for computed tomography (4.0 weeks), while the longest wait occurred in Saskatchewan (8.0 weeks). The median wait for an MRI across Canada was 12.3 weeks. Patients in Prince Edward Island experienced the shortest wait for an MRI (5.0 weeks), while Newfoundland residents waited longest (36.0 weeks). Finally, the median wait for ultrasound was 3.4 weeks across Canada. Both Alberta and Ontario displayed the shortest wait for ultrasound (2.0 weeks), while Newfoundland exhibited the longest ultrasound waiting time, 9.0 weeks.

Numbers of procedures for which people are waiting

The numbers of procedures for which people are waiting were also calculated. For the 2005 edition, we have continued to use the methodology first introduced in the eleventh edition, which allows the Institute to more accurately measure the number of procedures for which people are waiting. As well, a significant improvement in our estimation methodology implemented in 2003 allows us to more accurately estimate the number of procedures for which patients are waiting in 2005. Throughout Canada, the total number of procedures for which people are waiting in 2005 is 782,936, a decrease of 4 percent from the estimated 815,663 procedures in 2004. The number of procedures waited for rose in British Columbia, Alberta, Manitoba, Ontario, Nova Scotia, and Newfoundland. Assuming that each person was waiting for only one procedure, 2.48 percent of Canadians were waiting for treatment in 2005, which varied from a low of 1.87 percent in Prince Edward Island to a high of 5.32 percent in Saskatchewan. However, as noted in previous years, government of Saskatchewan data suggest that many patients in that province are admitted for multiple procedures, meaning that the estimate of the number of people waiting in that province may be greatly exaggerated.

Verification of the data

To attempt to corroborate the findings of this and previous surveys, current waiting time data were solicited from provincial governments, and past waiting time data were drawn from peer-reviewed journals. Provincial governments collect data that neither directly nor

easily compares with that collected by our survey. Nonetheless, even evidence from British Columbia, the jurisdiction where the wait times collected by government most startlingly clash with those published in this study, adds credibility to the Institute's estimates. The evidence from a comparison with academic research strongly suggests that the Institute's measurements may be biased downward, understating actual waiting times.

Summary: The magnitude of the problem and the importance of reform

Canada-wide total waiting time fell slightly in 2005, but its level is high, both historically and internationally. Compared to 1993, waiting time in 2005 is 90 per cent longer. Moreover, academic studies of waiting time have found that Canadians wait longer than Americans, Germans, and Swedes (sometimes) for cardiac care, although not as long as New Zealanders or the British.

Medical research has shown that longer waits can lead to adverse consequences for cardiac patients. Furthermore, economists attempting to quantify the cost of this waiting time have estimated it to amount to \$1,100 to \$5,600 annually per patient (Cullis and Jones, 1986; Propper, 1990).

The extent of Canada's health system dysfunction was documented in a 2000 Fraser Institute study that examined the impact of increases in government

health spending. The study's analysis revealed that provinces spending more on health care per person had neither shorter (nor longer) total waiting times than those spending less. In addition, those provinces spending more had no higher rates of surgical specialist services (consultations plus procedures) and had lower rates of procedures and major surgeries (Zelder, 2000b). A follow-up study in 2003 found that increased spending was actually correlated with *increases* in waiting times unless those increases in spending were targeted to physicians or pharmaceuticals (Esmail, 2003).

Finally, the promise of the Canadian health care system is not being realized. On the contrary, a profusion of recent research reveals that cardiovascular surgery queues are routinely jumped by the famous and politically-connected, that suburban and rural residents confront barriers to access not encountered by their urban counterparts, and that low-income Canadians have less access to specialists, particularly cardiovascular ones, and have lower cardiovascular and cancer survival rates than their higher-income neighbours.

This grim portrait is the legacy of a medical system offering low expectations cloaked in lofty rhetoric. Indeed, under the current regime—first-dollar coverage with use limited by waiting, and crucial medical resources priced and allocated by governments—prospects for improvement are dim. Only substantial reform of that regime is likely to alleviate the medical system's most curable disease—waiting times that are consistently and significantly longer than physicians feel is clinically reasonable.

Waiting Your Turn

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)

The measurement of medical waiting times is a frequent target of 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 times and the general state of the health care system. Consequently, consumers, as well as health providers and policy makers, rely on available data regarding waiting times. Among these data, The Fraser Institute's annual study is the only comprehensive study of waiting across provinces and medical specialties.

At the time of this fifteenth edition, the authors can feel some satisfaction in the fact that governments across Canada are now focusing on the issue of waiting times and making a reduction in waiting times a key health care priority. Specifically, the provinces, in an agreement with the prime minister, have agreed to establish "evidence-based benchmarks for medically acceptable wait times" for the "priority areas" of cancer, heart, diagnostic imaging, joint replacements, and sight restoration by the end of 2005, while multi-year targets to achieve those benchmarks will be established in each province by the end of 2007 (Martin, 2004). Similarly, some satisfaction arises from the fact that the survey is much imitated. Provincial health ministries are now more likely to monitor and collect waiting time data than ever before. A much-heralded example of this in years past was the decision by British Columbia's Ministry of Health to disseminate on-line waiting time information. In recent years, the

Alberta Ministry of Health and Wellness, the Saskatchewan Surgical Care Network, Manitoba Health, and the Quebec Ministry of Health and Social Services have begun allowing on-line access to current waiting time information in their respective provinces. 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 for 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 these are characteristics of the Canadian health care experience and, in each case, 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.

A number of health sector administrators are sceptical about the meaning and usefulness of waiting lists. They are sceptical 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, a forerunner to *Waiting Your Turn*, 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 5-province analysis similar to the initial study. Since 1992, all 10 provinces in Canada have been surveyed.

This fifteenth edition builds upon the Institute’s earlier studies by updating waiting list estimates for all provinces. The next section briefly reviews the relevant theoretical issues underlying these estimates.

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. In this case, the rationing 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” (Statistics Canada, 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. In 1994, Statistics Canada data showed that over one million Canadians felt that they needed care but did not receive it, and that approximately 30 percent of these people were in moderate or severe pain (Stat-

tics Canada, 1994/95). In 2000-01, Statistics Canada data showed that an estimated 4.3 million Canadians had difficulties obtaining routine care, health information or advice, immediate care for minor health issues, and other first contact services, and approximately 1.4 million Canadians had difficulties gaining access to specialist visits, non-emergency surgery, and selected diagnostic tests (Statistics Canada, 2002). Twenty percent of those who waited for the latter three specialized services indicated that the wait affected their lives; most of these people experienced “worry, stress, and anxiety, pain, or diminished health as a result of waiting” (Statistics Canada, 2002). Over 20 percent of the 1.4 million also indicated that their waiting time was unacceptable (Statistics Canada, 2002). The most recent Statistics Canada data, from 2003, show that an estimated 607,000 Canadians had difficulties getting to see a specialist, 201,000 had difficulties getting non-emergency services, and 301,000 had difficulties getting selected diagnostic tests: a total of 1.1 million Canadians (Statistics Canada, 2004). Between 10 and 19 percent of the Canadians who waited for these services indicated that the wait affected their lives. 60 to 72 percent of affected individuals experienced “worry, stress, or anxiety,” and 45 to 55 percent reported experiencing pain while waiting for these specialized services. Finally, between 17 and 29 percent of the individuals who waited for specialized services felt that their waiting time was unacceptable (Statistics Canada, 2004).

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 7 to 12 months, while only 14 percent of those in severe pain waited less than 4 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.

Moreover, adverse consequences from prolonged waiting are increasingly being identified and quantified in the medical and economics literatures. Beanlands *et al.*

(1998) assessed the impact of waiting time for cardiac revascularization on mortality, cardiac events (e.g., heart attacks), and heart functioning. Patients who were revascularized earlier had significantly lower pre-operative mortality than those who were revascularized later. As well, those treated earlier had a lower rate of subsequent cardiac events (a difference which approached statistical significance), and significant improvement in heart function (unlike the patients receiving later treatment). Similarly, Sampalis *et al.* (2001) found that those who waited longer for a coronary artery bypass graft had significantly reduced physical functioning, vitality, social functioning, and general health prior to surgery, and had reduced physical functioning, vitality, mental health, and general health 6 months after surgery. The patients who waited longer were also more likely to experience an adverse postoperative event, and were less likely to return to work after surgery.

Morgan, Sykora, and Naylor (1998) examined the effect of waiting on death rates among patients waiting for heart surgery. In their analysis, those who waited longer for surgery, both in absolute terms and relative to the maximum wait recommended, had a higher probability of death while waiting. In a related inquiry, Rosanio *et al.* (1999) found that those who waited longer for coronary angiography were more likely to suffer the adverse consequences of cardiac hospitalization, heart attack, and cardiac-related death.

To express more concretely the cost of these effects on morbidity and mortality, economists have attempted to infer the monetary costs associated with waiting for treatment. Because paying for private care is the alternative to waiting for publicly-provided care in the UK, Cullis and Jones (1986) deduce that the cost of waiting for treatment in terms of reduced morbidity and mortality is, at a maximum, the cost of private care. Taking the actual costs of private care for a variety of important and common treatments, Cullis and Jones (1986) estimate that the cost of waiting in the UK in 1981 was about \$5,600 per patient. Alternatively, Gliberman (1991) treats waiting time as a period during which productive activity (either for pay or in the household) is potentially precluded. Thus, the cost of a day of waiting is the wage or salary forgone, for which Gliberman uses the Canadian average wage. Only those who report experiencing “significant difficulties in carrying out their daily activities,” about 41 percent of those

waiting, are counted as bearing the cost of lost wages, meaning that the cost per patient was about \$2,900 in Canada in 1989. Using the same methodology, but with a 10 percent loss of productivity in place of Gliberman’s procedure-specific measures (which averaged 41 percent), Esmail (2005) estimated the cost of waiting per patient to be nearly \$900 per patient in 2004 if only hours during the normal working week were considered “lost,” and as much as \$2,700 if all hours of the week (minus 8 hours per night sleeping) were considered “lost.” Finally, Propper (1990) estimates the cost of waiting by an experiment in which subjects were asked to choose between immediate treatment (at a varying range of out-of-pocket costs), and delayed treatment (at a varying range of time intervals) at no out-of-pocket cost. From this, she determined that cost per patient was approximately \$1,100 in the UK in 1987.

The idea that waiting can impose costs can be considered via the analogy of wartime rationing of (essentially imposed waiting for) refrigerators or automobiles. Those who wanted refrigerators in 1940 but did not get them until 1946 were not denied the refrigerators; they only had to wait. Clearly, the issue of time is important in goods provision; delay of availability undoubtedly made those waiting worse off. This same logic also applies, sometimes vitally, in the provision of medical services.

Non-price rationing and methods of adapting

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 government-imposed 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. In other words, 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 procedures 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. In fact, many inequities have been discovered in the current system. Preferential access to cardiovascular surgery on the basis of “nonclinical factors” such as personal prominence or political connections is common (see Alter, Basinski, and Naylor, 1998). As well, residents of suburban Toronto and Vancouver have been found to experience longer waiting times than do their urban counterparts (Ramsay, 1997) and residents of northern Ontario receive substantially lower travel reimbursement from the provincial government than do southern Ontarians when travelling for radiation treatment (Priest, 2000; and Ombudsman Ontario, 2001). Finally, low-income Canadians are less likely to visit medical specialists (Dunlop, Coyte, and McIsaac, 2000), including cardiac specialists, and have lower cardiac and cancer survival rates (Alter *et al.*, 1999; Mackillop, 1997) than higher-income Canadians. This evidence indicates that rationing by waiting is often a facade for a system of personal privilege, and perhaps even greater inequality than rationing by price. Moreover, perceived inequity in the distribution of medical services due to perceived inequity in income distribution can be better rectified by lump-sum income transfers, or subsidies for the purchase of health insurance by the poor, than by non-price rationing.

To be sure, many arguments 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.

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 and mortal consequences from non-treatment and those whose life expectancy would be least improved by treatment. The British experience suggests that some doctors use a forgone-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 radiation machines to provide palliative care or limited extensions to life expectancy (*Globe and Mail*, 1989, p. A1).

Canadians may be adapting to non-price rationing by substituting private services for unavailable public services 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 now companies in Ontario, Quebec, Alberta, British Columbia, and elsewhere in Canada that either expedite care in Canada through various legislative loopholes, or facilitate diagnostic testing and treatment in the United States. In addition, American medical centres have been known to advertise in Canadian newspapers. This year's survey of specialists (reported later in this study) found that 1.1 percent of patients received treatment in another country during 2005.

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 substantial 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, for example, 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 over-prescribe 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 sceptical 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-booked for treatment.

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. Moreover, empirical verification of the Institute’s survey numbers (to be discussed in the two “Verification ...” sections) yields no evidence of upward bias.

National 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). In those instances where data from institutions are available, they have been used to corroborate the evidence from the survey data. Further, specialists rather than general practitioners were surveyed because specialists have primary responsibility for health care management of surgical candidates.

The survey was conducted in all 10 Canadian provinces. Cornerstone List Fulfillment provided mailing lists, drawn from the Canadian Medical Association’s membership rolls, for the specialists polled. Specialists were offered a chance to win a \$2,000 prize (to be randomly awarded) as an inducement to respond. Survey questionnaires were sent to practitioners of 12 different medical specialties: plastic surgery, gynaecology, ophthalmology, otolaryngology, general surgery, neurosurgery, orthopaedic surgery, cardiac and vascular surgery, urology, internal medicine, radiation oncology, and medical oncology. The original survey (1990) was pre-tested 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 10 specialties originally surveyed.

The questionnaire used for general surgery is found in Appendix 2. The questionnaires for all of the specialties follow this format (with slight variations for medical and radiation oncology and cardiac and vascular surgery); only the procedures surveyed differ across the various specialty questionnaires. Medical specialists in Quebec and New Brunswick who indicate that their language of preference is French are sent French-language surveys. The data for this issue of *Waiting Your Turn* were collected between January 10 and April 8, 2005.

For the most part, the survey was sent to all specialists in a category. In the case of internal medicine in Ontario, a 50 percent sample was taken in the cities of Hamilton, London, North York, Ottawa, Toronto, and Scarborough. 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 was 29 percent overall, two percent below that 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. (Definitions of procedures are found in Appendix 3.) Specialty boards of the British Columbia Medical Association suggested the origi-

nal list of procedures in 1990, and procedures have been added since then at the recommendation of survey participants.

At the suggestion of the Canadian Hospital Association, since 1995 waiting time 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, extremely long waiting times reported by a few specialists), 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.¹ 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 15. Table 2 reports the total median time a patient waits for treatment from referral by a general practitioner. To obtain the provincial medians—found in the last row of table 2 (and of tables 3, 4, and 13), and the national median—found in the last column of table 2 (and of tables 3, 4, and 13), the 12 specialty medians are each weighted by a ratio: the number of procedures done in that specialty in the province divided by the total number of procedures done by specialists of all types in the province.

Tables 3 and 4 present median waiting times compared among specialties and provinces. Table 3 summarizes the first stage of waiting, that between the referral by a general practitioner and consultation with a specialist. Table 4 summarizes the second stage of waiting: that between the decision by a specialist that treatment is required and the treatment being received.

Tables 5a through 5l report the time a patient must wait for treatment, where the waiting time per patient is the median of the survey responses. The provincial weighted medians reported in the last line 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.

Table 6 provides the percentage change in median waits to receive treatment after the first appointment with a specialist between the years 2004 and 2005. Table 7 provides frequency distribution data indicating the proportion of survey waiting times that fall within various lengths of time among provinces.

Table 8 summarizes clinically “reasonable” waiting times among provinces and specialties. Tables 9a through 9l report the median values for the number of weeks estimated by specialists to be clinically reasonable lengths of time to wait for treatment after an appointment with a specialist. The methodology used to construct these tables is analogous to that used in tables 5a through 5l.

Table 10 summarizes the actual versus clinically “reasonable” waiting times among provinces and specialties. Table 11 summarizes the percentage of patients reported as receiving treatment outside Canada among provinces and specialties.

Table 12 presents the estimated number of procedures for which people are waiting, compared among specialties and provinces. Because the questionnaires omit some less commonly-performed procedures, the sum of the numbers of procedures for which people are waiting for each specialty in table 12 is, of course, an underestimate of the total number waiting.

The number of non-emergency procedures for which people are waiting that were not included in the survey was also calculated, and is listed in table 12 as the “residual” number of procedures for which people are waiting. To estimate this residual number, the number of non-emergency operations not contained in the sur-

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.

vey that are done in each province annually must be used. This residual number of operations (compiled from the CIHI data) is then divided by 52 (weeks) and multiplied by each province's weighted median waiting time.

Tables 13a through 13l report the estimated number of procedures for which people are waiting. To allow for interprovincial comparisons, table 14 summarizes the number of procedures for which people are waiting per 100,000 population among specialties and provinces. Table 15 provides the percentage change in the number of procedures for which people were waiting between 2004 and 2005.

To estimate the number of procedures for which people are waiting, the total annual number of procedures is divided by 52 (weeks per year) and then multiplied by The Fraser Institute's estimate of the actual provincial average number of weeks waited. 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.

Previously, as noted, the average of survey waiting times was used to provide an estimate of the actual provincial average waiting time (an unobservable measure of the actual patient experience in a province). Continued concerns over exceptionally large numbers of procedures waited for in Saskatchewan led to a revision in the methodology in 2003 to replace the average waiting time measure with the median waiting time measure to estimate the actual patient experience in each province. This change provides a more accurate estimate of the actual number of procedures waited for across Canada, and makes The Fraser Institute's estimates less susceptible to influence from outlier responses (described above).

This study's weighting of medians and the estimation of the number of procedures for which patients are waiting are based on data from the Canadian Institute for Health Information's Discharge Abstract Database (DAD) and National Ambulatory Care Reporting System (NACRS) for 2003-2004. This data is categorized using

the ICD-10/CCI data standard. It should be noted that New Brunswick data for 2002-03 (used in the 14th edition of *Waiting Your Turn*) were reported to CIHI using the older ICD-9/CCP data standard, while all other provinces (where data is available and complete) reported data for that year using the newer ICD-10/CCI standard. Since these two formats are not easily comparable, procedure counts for New Brunswick for the 14th edition of *Waiting Your Turn* were estimated using the same methodology employed for counts in Alberta, Manitoba, and Quebec outlined below. Thus, the change in the number of procedures for which patients are waiting from 2004 to 2005 should be interpreted with caution for New Brunswick this year because it also reflects a change from an estimation of procedures to an actual count.

Health departments in Manitoba and Quebec do not provide CIHI with discharge data. Alberta Health does not provide CIHI with discharge data for same-day surgeries. CIHI assembles Manitoba data based on data submitted directly to CIHI by facilities across the province. Other facilities, which perform a significant number of surgeries in Manitoba, are excluded. The authors made a pro-rated estimate of procedures in Alberta, Manitoba, New Brunswick, and Quebec using the 1999-2000 number of hospitalizations from data published by CIHI.

There are a number of minor problems in matching CIHI's categories of operations to those reported in The Fraser Institute survey. In a few instances, an operation such as rhinoplasty is listed under more than one specialty in *Waiting Your Turn*. In these cases, we divide the number of patients annually undergoing this type of operation among specialties according to the proportion of specialists in each of the overlapping specialties; e.g., if plastic surgeons constitute 75 percent of the group of specialists performing rhinoplasties, then the number of rhinoplasties counted under plastic surgery is the total multiplied by .75. A second problem is that, in some cases, an operation listed in the *Waiting Your Turn* questionnaire has no direct match in the CIHI tabulation. In these cases, we make no estimate of the number of patients waiting for these operations.

We expect, in coming years, to further improve our estimates for Manitoba, Alberta, and Quebec. We also anticipate being able to improve our estimates for

ophthalmologic surgery, where a significant number of the surgeries occur in private facilities and, as a result, are not included within the discharge data submitted to, or reported by, CIHI. Table 16a summarizes the number of acute inpatient discharges by procedure, while table 16b summarizes the number of same-day surgery discharges by procedure.

Verification of current data with governments

In July 2005, we sent preliminary data across Canada to provincial ministries of health, and to provincial cancer and cardiac agencies. As of September 2005, we received replies from provincial health ministries in Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia, as well as the BC Cancer Agency and Cancer Care Ontario. The BC Ministry of Health, the Alberta Ministry of Health and Wellness, the Saskatchewan Surgical Care Network, the Manitoba Ministry of Health, the Quebec Ministry of Health and Social Services, Cancer Care Ontario, and the Cardiac Care Network of Ontario publish current wait list data on their web sites providing waiting times and/or the numbers of patients waiting. The Ontario Ministry of Health and Long Term Care provides access to wait time information from a report on waiting times in Ontario in 2003-04.

Many provinces measure the waiting time as the time between the date on which a treatment is scheduled (or booked) and the date of the treatment. The Fraser Institute intends to assist those seeking treatment, and those evaluating waiting times, by providing comprehensive data on the entire wait a person seeking treatment can expect. Accordingly, the Institute measures the time between the decision of the specialist that treatment is required and treatment being received.

Alberta

The Alberta Ministry of Health and Wellness' web site presents median waiting times for all non-urgent surgeries performed in the province over the past 90 days, from the specialist's decision to treat. By comparison, The Fraser Institute reports prospective median waiting times for elective procedures from the specialist's decision to treat the patient.

Chart 1: Comparison of Waiting Times in Alberta, Specialist to Treatment, 2005

Specialty/ Procedure	AB Health Non-Urgent Wait Time ¹	Fraser Institute Median Wait ²
Plastic Surgery	6	21.0
Gynaecology	7	6.9
Ophthalmology	10	8.4
Cataract Surgery	12	11.0
Otolaryngology	7	8.3
General Surgery	5	5.4
Cholecystectomy	5	6.0
Neurosurgery	4	5.8
Orthopaedic Surgery	12	26.7
Hip Replacement Surgery	20	40.0
Knee Replacement Surgery	25	40.0
Cardiac/Thoracic/Vascular Surgery	2/3/3	5.9
Coronary Artery Bypass Surgery	1	6.0
Urology	5	3.4
MRI Scans	7	10.0
CT Scans	3	5.5

¹Actual median wait for patients served in the 90 days preceding April 30, 2005.

²Prospective median wait, national hospital waiting list survey, 2005.

Sources: Alberta Ministry of Health and Wellness (2005); and The Fraser Institute's national waiting list survey, 2005.

There is a substantial difference between the measurement of prospective waiting times (the expected waiting time for the next patient) and retrospective waiting times (the amount of time the patient actually waited for surgery). Notably, the latter measure will include any delays between the decision to treat the patient and the formal booking/recording for that patient, and any adjustments in waiting times that were the result of a deterioration in the patient's condition or from adjustments that resulted from other uncontrollable factors (emergency cases using up operating room time, an earlier operating slot becoming available, etc.).

Chart 2: Number of Patients Waiting for Care, Alberta, 2005

Specialty/ Procedure	Alberta Ministry of Health and Wellness Count ¹	Fraser Institute Estimate
Plastic Surgery	3,031	2,019
Gynaecology	5,041	3,120
Ophthalmology	11,673	4,740
Cataract Surgery	9,426	3,651
Otolaryngology	4,126	1,819
General Surgery	6,358	5,141
Cholecystectomy	893	788
Neurosurgery	553	448
Orthopaedic Surgery	12,127	11,317
Cardiac, Thoracic, and Vascular Surgery	1,589	182
Coronary Artery Bypass Surgery	277	82
Urology	2,463	2,108

¹Count as at April 30, 2005.

Sources: Alberta Ministry of Health and Wellness (2005); and The Fraser Institute's national waiting list survey, 2005.

Despite these differences in methodology, it appears that the prospective wait times from The Fraser Institute's waiting list survey are broadly similar to the retrospective waiting times available from the Alberta Ministry of Health and Wellness' web site (chart 1). Only in the areas of Plastic Surgery, Otolaryngology, Neurosurgery, Orthopaedic Surgery, Cardiac Surgery, and diagnostic scanning services do the two measurements differ significantly.

The number of patients waiting published on the Ministry's web site are also broadly similar to The Fraser Institute's estimates of the number of procedures for which patients are waiting (chart 2). Despite the substantial differences in methodology mentioned above, it appears that in most cases The Fraser Institute's estimates of procedures for which patients are waiting either closely approximates or underestimates the actual experience in Alberta.

British Columbia

In British Columbia, the Ministry of Health defines waiting time in such a way that its estimates are shorter than those in this survey. Specifically, the ministry defines a wait as the interval between the time the procedure is formally booked 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 also understates the patient's actual waiting time between seeing a specialist and receiving treatment. In addition, 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).

One additional difference between the measures published on the Ministry of Health's web site and those produced by The Fraser Institute is that the ministry's measurement includes all "booked" procedures, even if the booking was less than 24 hours prior to surgery. This suggests that many non-elective surgeries may be included in the Ministry of Health's measurements. By contrast, The Fraser Institute's measurements, with the exception of cardiovascular surgery wait times, include wait times for only elective procedures.

These differences in methodology suggest that the wait times published on the BC Ministry of Health's web site should be substantially shorter than those measured by The Fraser Institute. However, in years past the BC Ministry of Health's wait times have also been found to be remarkably low when compared to the number of procedures actually completed and the number of patients reported to be waiting for treatment.

While the ministry no longer provides information about the number of procedures completed alongside the wait times and patients waiting, it is possible to use the number of procedures reported in 2004 as an estimate of procedures completed in 2005 to determine the validity of the current wait time information. This estimate of procedures can be combined with the count of patients waiting to determine the amount of time it would take to empty the list of patients who are currently waiting for care (which serves as an estimate of the waiting time the next patient added to the list will experience). That calculation, shown in charts 3

Chart 3: Number of Patients Waiting for Care, British Columbia

Specialty/Procedure	Patients Waiting ¹	Fraser Institute Estimate	Estimated Number of Procedures per Week Required 2005	Number of Procedures Performed per Week in 2004
Plastic Surgery	4,337	3,737	774.5	142.1
Gynaecology	5,573	4,328	1,393.3	345.8
Ophthalmology	13,575	10,810	1,939.3	449.2
Cataract Surgery	12,639	8,589	1,599.9	369.6
Cornea Transplant	548	383	37.3	11.2
Otolaryngology	5,200	2,914	963.0	179.2
General Surgery	11,533	8,507	3,720.3	631.4
Neurosurgery	1,300	848	333.3	73.0
Orthopaedic Surgery	19,485	21,194	2,405.6	410.7
Hip and Knee Replacement Surgery	8,210	15,250	331.0	94.3
Cardiac and Vascular Surgery	1,120	294	403.4	100.5
Urology	4,843	6,038	1,181.2	312.0
Radiation Oncology	320	—	457.1	199.3

¹Count as at May 31, 2005.

Sources: British Columbia Ministry of Health Services Wait List web site; and The Fraser Institute's national waiting list survey, 2005.

and 4, shows that the wait times presented on the ministry's web site continue to be critically flawed.

For example, the ministry reports a waiting time of 5.6 weeks for plastic surgery for the three months ending May 31. The web site also shows 4,337 patients waiting for surgery at that time (charts 3 and 4). In order for the waiting time for the next patient placed on the waiting list to be 5.6 weeks, the province would have to provide 775 procedures per week, nearly four and a half times the number of surgeries delivered weekly in 2004 (chart 3). In other words, either the province has expanded surgical capacity by more than 400 percent in one year, or this waiting time simply cannot be correct.

Either there are fewer people waiting, a lot more surgeries being completed, or the government's number of a 5.6-week wait for plastic surgery is flat wrong! Specialty by specialty, month in and month out, the median wait figures reported by the ministry remain consistently, and surprisingly, lower than expected given the number of patients waiting and the number of procedures that can reasonably be expected to be performed per week. Chart 3 provides information on the current number of patients waiting for surgery, The Fraser Institute's estimates of the number of proce-

dures for which patients are waiting, the number of procedures that would have to be accomplished weekly if the Ministry of Health's wait time figures are correct, and the number of procedures completed weekly in 2004. Chart 4 shows the ministry's published waiting times, the "expected" waiting time for the next patient placed on the waiting list using either the number of procedures provided weekly in 2004 or that figure plus 10 percent, and The Fraser Institute's median waiting time measurements.

For the three months ending May 31, 2005, the government's reported median wait averaged 29 percent of the "expected" wait (including a 10 percent increase in surgical volume from 2004), ranging from 19 percent (for general surgery and orthopaedic surgery) to 50 percent (for cardiac surgery). The Institute median wait data, meanwhile, averages 64 percent of the "expected" wait.

It should be noted that the Ministry of Health has found their counts of patients waiting for treatment to be highly problematic—many patients have been treated and not removed from waiting lists while others who are still on waiting lists are deceased. This suggests that the "expected" wait may be overstating the

Chart 4: Comparison of Reported Waiting Times in British Columbia, Specialist to Treatment

Specialty/Procedure	BC Health Median Wait ¹	Implied 2005 Expected Wait (2004 Procedures/Week) ²	Implied 2005 Expected Wait (2004 Procedures/Week + 10%) ³	Fraser Institute Median Wait ⁴
Plastic Surgery	5.6	30.5	27.7	24.2
Gynaecology	4.0	16.1	14.7	8.0
Ophthalmology	7.0	30.2	27.5	10.8
Cataract Surgery	7.9	34.2	31.1	12.0
Cornea Transplant	14.7	48.9	44.5	42.0
Otolaryngology	5.4	29.0	26.4	10.7
General Surgery	3.1	18.3	16.6	7.6
Neurosurgery	3.9	17.8	16.2	9.1
Orthopaedic Surgery	8.1	47.4	43.1	33.9
Hip Replacement Surgery	22.9	67.6	61.5	54.0
Knee Replacement Surgery	26.0	103.5	94.1	54.0
Cardiac Surgery	8.0	17.5	15.9	8.8
Vascular Surgery	2.1	9.5	8.6	8.8
Urology	4.1	15.5	14.1	7.2
Radiation Oncology	0.7	1.6	1.5	—

¹Retrospective median wait time for the 3 months ending May 31, 2005.

²Number of weeks to exhaust the list of patients waiting if procedure counts in 2005 are unchanged from 2004 (patients waiting at May 31, 2005/Procedures per week in 2004).

³Number of weeks to exhaust the list of patients waiting if procedure counts in 2005 have increased by 10 percent from the 2004 level (patients waiting at May 31, 2005/(Procedures per week in 2004 x 110 percent)).

⁴Prospective median wait, national hospital waiting list survey, 2005.

Sources: British Columbia Ministry of Health Services Wait List web site; and The Fraser Institute's national waiting list survey, 2005.

wait times in British Columbia. However, the number of patients waiting for treatment would have to drop to roughly one-quarter the current reported level in order for the ministry's measurements of waiting times to be consistent with the number of patients waiting and procedures being performed. In other words, the true patient experience in British Columbia likely lies somewhere between the "expected" wait estimated above and the wait time reported by the ministry, which is precisely where the wait times and estimates of procedures for which patients are waiting produced by The Fraser Institute generally lie.

Saskatchewan

The Saskatchewan Surgical Care Network (SSCN) wait list web site provides measures of waiting times from the provincial registry for surgeries in most areas of

Saskatchewan. The measures presented by Saskatchewan are for non-emergent surgeries and measure the wait from when a booking was made to when the procedure was completed. As noted above, this methodology differs significantly from that used by The Fraser Institute.

One of the differences between the wait times presented here and those available on the SSCN web site is a difference between measuring at the time a new patient is seen by the specialist, and when the booking for the procedure is actually made. There are a number of systemic delays that can occur between the time the patient is seen by a specialist and the time a booking is made, the first being that there is often a delay to order and complete tests and analyze the test results (in particular, imaging scans). Another delay relates to the fact that there may be a wait list to make the actual booking. A telephone survey of Saskatchewan physi-

Chart 5: Comparison between Saskatchewan Surgical Care Network Wait List Measures (October 2004 to March 2005) and *Waiting Your Turn* 2005

Specialty/Procedure	SSCN Wait	SSCN Elective Wait ¹	Fraser Institute Median
Plastic Surgery	23.4	38.5	48.1
Mammoplasty/Operations on Breast (3, 5)	49.1	51.4	70.0
Gynaecology	10.3	20.2	15.1
Dilation and Curettage (1-7)	2.3	25.8	5.0
Tubal Ligation (1, 3-7)	12.4	17.3	24.0
Hysterectomy (1-7)	16.1	20.9	20.0
Ophthalmology	26.7	31.2	27.6
Cataract Surgery (1-7)	28.3	31.0	33.0
Otolaryngology	24.1	39.3	45.1
Myringotomy (3-7)	3.8	7.7	5.0
Tonsillectomy (3, 5-7)	36.4	44.1	83.5
General Surgery	6.9	17.2	9.7
Hernia Repair (1-7)	16.2	23.4	14.0
Cholecystectomy (1-7)	9.0	19.2	14.0
Breast Biopsy (1, 3, 5-7)	2.4	5.1	3.0
Mastectomy (3)	2.4	4.9	3.0
Neurosurgery	10.8	27.3	8.5
Disc Surgery/Laminectomy (3, 5)	17.6	30.5	14.0
Orthopaedic Surgery	20.7	36.1	37.1
Hip Replacement (1, 3, 5, 6)	28.9	36.0	42.0
Knee Replacement (1, 3, 5, 6)	46.1	48.1	42.0
Removal of Pins/Removal of Bone Support (3, 5, 6)	20.6	28.5	18.0
Cardiovascular Surgery	4.1	18.1	1.5 (Urgent)
Bypass Surgery (3, 5)	3.9	15.9	2.0 (Urgent)
Valves and Septa (3, 5)	6.2	15.3	2.0 (Urgent)
Cardiovascular Surgery	4.1	18.1	3.6 (Elective)
Bypass Surgery (3, 5)	3.9	15.9	4.0 (Elective)
Valves and Septa (3, 5)	6.2	15.3	4.0 (Elective)
Urology	14.2	25.5	13.2
Non-Radical Prostatectomy (3-6)	19.3	35.0	79.0
Radical Prostatectomy (3, 5)	14.0	15.1	7.3
Bladder Resection (3, 5, 6)	4.5	9.9	5.3
Cystoscopy (1, 3-6)	9.5	16.2	3.5
All Procedures/Specialties	17.0	29.7	18.3

Note: Saskatchewan Surgical Care Network data is presented as a proportion of patients who received their surgery within certain time frames. This comparison is made based on a weighted measure of the mid-point of each time frame. For example, 38 percent of patients in Saskatchewan waited less than 24 hours for Neurosurgery, 25 percent waited 24 hours to 3 weeks, 10 percent waited 3 to 6 weeks, 7 percent waited 6 weeks to 3 months, 10 percent waited 4 to 6 months, 4 percent waited 7 to 12 months, 2 percent waited 13 to 18 months, and 5 percent waited more than 18 months. Taking the midpoints of each time frame to be .07, 1.6, 4.5, 9.5, 21.7, 41.2, 67.2, and 82 weeks respectively gives an average waiting time of 10.8 weeks. In addition, the SSCN web site does not provide wait times for individual procedures on a provincial basis. Provincial wait times have been developed for this comparison by producing a median wait time for each health region using the methodology shown above, and then weighting these wait times by the number of "patients completed."

¹SSCN Elective wait is measured by eliminating the 0-3 week time frame in the weighted average measure. SSCN measures non-emergent surgeries, which includes both urgent and elective cases. In order to allow better comparability with the waiting times for elective treatment presented in *Waiting Your Turn*, the two shortest time frames are removed from the SSCN's measurements in an attempt to eliminate the measure of urgent procedures.

Note: Not all health regions reported waiting times for all procedures. Reporting regions are denoted next to the procedure name by the following codes: (1) Five Hills, (2) Cypress, (3) Regina Qu'Appelle, (4) Sunrise, (5) Saskatoon, (6) Prince Albert Parkland, (7) Prairie North.

Chart 6: Comparison between Patients Waiting According to Saskatchewan Surgical Care Network Wait List Measures and Procedures for which Patients are Waiting Estimate from *Waiting Your Turn* 2005

Specialty	SSCN Count	FI Estimate
Plastic Surgery	2,065	2,039
Gynaecology	2,702	2,146
Ophthalmology	7,759	8,123
Otolaryngology	3,426	4,025
General Surgery	3,495	3,689
Neurosurgery	586	218
Orthopaedic Surgery	7,182	6,237
Cardiovascular Surgery	229	64
Urology	1,633	3,466
Overall Count	30,277	52,931

Note: SSCN Patients waiting count at March 31, 2005.

Sources: Saskatchewan Surgical Care Network wait list web site and The Fraser Institute's national waiting list survey, 2005.

cians conducted by the authors of *Waiting Your Turn* in 2002 revealed that at least some of the physicians did not place their elective patients on the government waiting list until the patients became urgent cases. Thus, waiting times that measure from booking time to actual procedure will not capture the waiting times for testing and any delays in booking that occur.

The crucial difference between the two measures, however, is the inclusion of urgent surgeries. The SSCN web site measures waiting times for all non-emergent surgeries (i.e., urgent and elective surgery waits are measured), while *Waiting Your Turn* measures waiting times for only elective surgeries. This means that urgent wait times (which are significantly shorter than elective wait times) are included in the wait time measures available on the SSCN web site but not in those measured by The Fraser Institute.

The resulting conclusion is that the numbers available on the SSCN web site are not directly comparable to those measured in *Waiting Your Turn*.

Despite these differences in methodology, it appears that The Fraser Institute's estimates of waiting times in Saskatchewan either closely approximate or underesti-

mate the actual experience in that province in most cases (chart 5). Only in the cases of Plastic Surgery, Otolaryngology, Tubal Ligation, and Non-Radical Prostatectomy are the Institute's estimates notably longer than the wait times reported on the SSCN's web site.

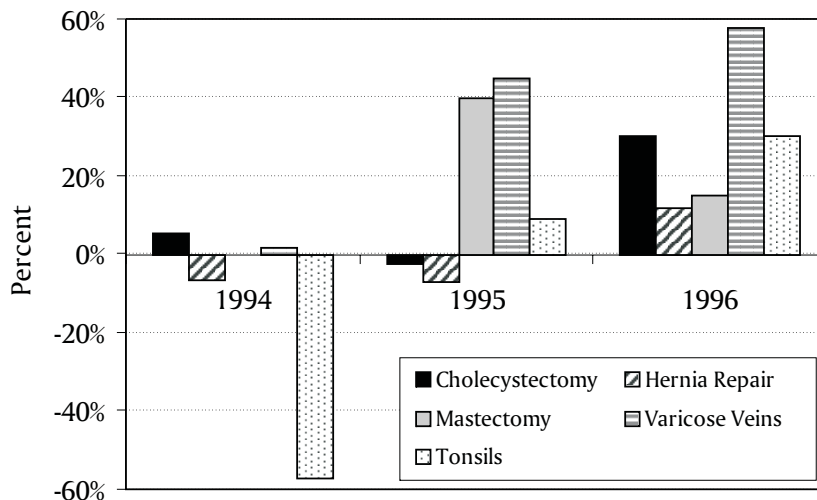
The Fraser Institute's estimates of procedures for which patients are waiting also approximate the counts of patients waiting for care produced by SSCN. Only in the cases of Otolaryngology, Urology, and the overall count of procedures for which patients are waiting are The Fraser Institute's estimates notably larger than the measures produced by SSCN (chart 6). It should be noted however, that much of this difference may arise from differences in what is being measured: the SSCN's counts include only patients waiting for procedures done in operating rooms and do not count patients who will be treated in "other locations such as procedure rooms," while The Fraser Institute's estimates include counts for all patients treated in hospitals.

Verification and comparison of earlier data with independent sources

The waiting list data can also be verified by comparison with independently computed estimates, primarily found in academic journals. Six studies predate the Institute's data series, and thus offer an informal basis for comparison. A brief survey of Ontario hospitals undertaken in October 1990 for the General Accounting Office of the United States Government (1991) indicates that patients experienced waits (after seeing a specialist and before receiving treatment) for elective orthopaedic surgery ranging from 8.5 weeks to 51 weeks, for elective cardiovascular surgery ranging from 1 to 25 weeks, and for elective ophthalmology surgery ranging from 4.3 to 51 weeks. The new survey data presented here (in table 4) finds typical Ontario patients waiting 21.9 weeks for orthopaedic surgery, 3.5 weeks for elective cardiovascular surgery, and 16.1 weeks for ophthalmology procedures in 2005.

A study of waiting times for radiotherapy in Ontario between 1982 and 1991 (Mackillop *et al.*, 1994) found that the median waiting times between diagnosis by a general practitioner and initiation of radiotherapy for carcinoma of the larynx, carcinoma of the cervix, and

Chart 7: Waiting Times—Difference between Manitoba Centre for Health Policy and Evaluation and The Fraser Institute



Source: DeCoster *et al.*, 1998, and The Fraser Institute's national waiting list surveys.

non-small-cell lung cancer were 30.3 days, 27.2 days, and 27.3 days, respectively. In Ontario in 2005, the wait for radiotherapy was approximately 28 days for cancer of the larynx, 28 days for cancer of the cervix, and 30 days for lung cancer (see tables 3 and 5k). However, the 2005 estimate that the median wait for prostate cancer treatment was 42 days is notably lower than Mackillop's estimate of 93.3 days.

A study of knee replacement surgery in Ontario found that in the late 1980s, the median wait for an initial appointment with an orthopaedic specialist was 4 weeks, while the median waiting time to receive a knee operation was 8 weeks (Coyte *et al.*, 1994). By comparison, the Institute's survey finds that in Ontario in 2005, the wait to see an orthopaedic specialist was 12.5 weeks (see table 3) and the wait to receive hip or knee surgery was 30.0 weeks (see table 5g).

Examination of waiting times for particular cardiovascular treatments in 1990 by Collins-Nakai *et al.* (1992) focused on three important procedures. They estimated median Canadian waiting times of 11 weeks for angioplasty and 5.5 months for cardiac bypass surgery. In comparison, 2005 median waiting times for "angiography/angioplasty" ranged from 4.0 weeks in Ontario, Quebec, and Newfoundland to 20.0 weeks in

New Brunswick (see table 5j), and for elective cardiac bypass ranged from 3.0 weeks in Ontario to 54.0 weeks in Newfoundland (see table 5h).

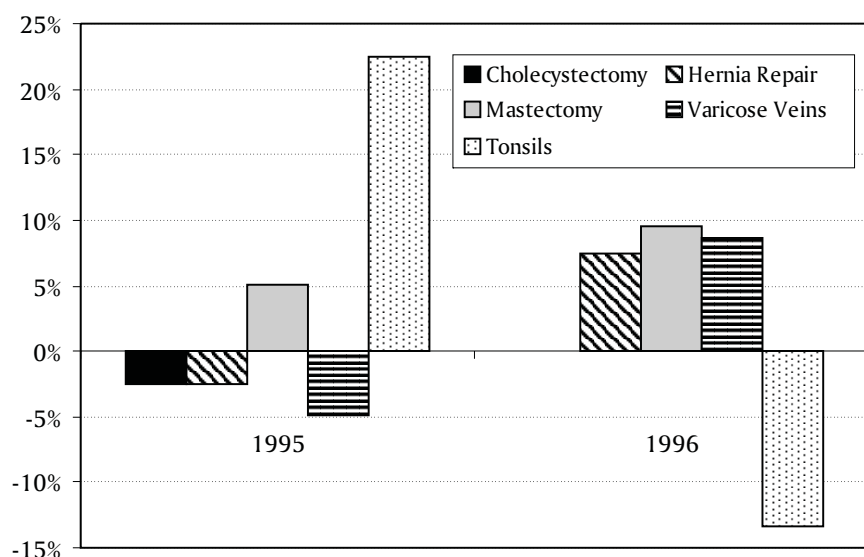
A study of waiting times for selected cardiovascular procedures in 1992 found that in Canada, 13.3 percent of waiting times for elective coronary bypass surgery fell in the 2-to-6-week range, with 40 percent in the 6-to-12-week range, 40 percent in the 12-to-24-week range, and 6.7 percent in the over-36-weeks range (Carroll *et al.*, 1995). Again, the 2005 data indicate that the provincial waiting time for elective bypass surgery (between specialist consultation and treatment) ranged from 3.0 weeks in Ontario to 54.0 weeks in Newfoundland (see table 5h).

Regarding waiting time for coronary artery bypass in Ontario in the early 1990s, Morgan *et al.* (1998) discovered that the median and mean waits were 18 and 38 days, respectively. By comparison, the 2005 Ontario survey data reveal waiting times for emergent, urgent, and elective bypass surgery of 0, 7, and 21 days respectively (see table 5h).

Six more recent studies permit direct comparison of Fraser Institute waiting times and independently derived estimates. DeCoster *et al.* (1998) obtained median waiting times for 5 common surgical procedures in Manitoba and compared them to Fraser Institute estimates of waiting times for those procedures. Waiting times for the five procedures—cholecystectomy, hernia repair, excision of breast lesions, varicose veins stripping and ligation, and tonsillectomy—were compared for the years 1994 to 1996. For 11 of the 15 comparisons (five procedures over three years) DeCoster *et al.* found that the Fraser Institute's measures of waiting times in Manitoba were actually equal to or shorter than those measured by MCHPE (chart 7).

The data gathered by the Manitoba Centre for Health Policy Evaluation provide further valuable insights about the reliability of The Fraser Institute waiting list survey. One of the concerns of Institute researchers

Chart 8: Fluctuation in Manitoba Centre for Health Policy and Evaluation Waiting Times, 1995 and 1996



Source: DeCoster *et al.*, 1998; calculations by authors.

over the years has been the apparent variability of the waiting time estimates. The normal presumption in measuring process fluctuations is that they will be modest in comparison to the size of the process being measured. This would predict swings in waiting times of, say, 10 or 15 percent from year to year. Numbers larger than this raise questions about whether the measurement method is subject to “noise.”

Since for nearly a decade The Fraser Institute’s waiting list measurements have been the only systematic ones available, the Institute has had no way to discern whether the sometimes dramatic swings in measurements are real or are induced by the sampling procedure. Comparable measurements by the Manitoba Centre, which are based on individual physician experience, cast some welcome light on the matter.

As chart 8 shows, the data from DeCoster *et al.* (1998) for two adjacent measurement periods—1995 and 1996—reveal very wide swings in the *ex post* waiting time experienced by patients. Tonsillectomy wait times increased by 22 percent in 1995 only to fall 13 percent the following year, a total swing of 35 percent. Varicose vein surgery waits swung by nearly 14 percent in the same period, and hernia repair waits by nearly 10 percent. Since these *ex post* surgery waiting times

do not include the pre-booking wait times that specialists record in The Fraser Institute survey data, it is likely that the swings estimated by the Manitoba data underestimate the extent of the actual fluctuation.

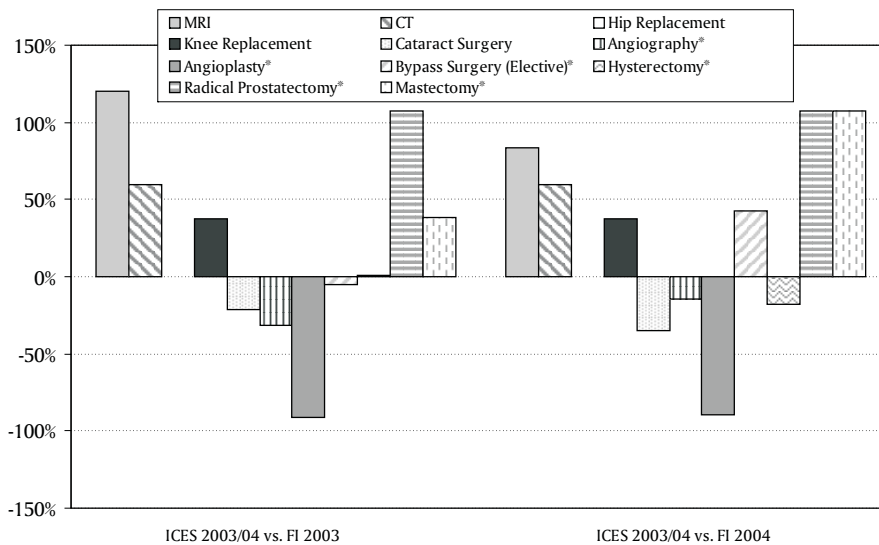
Overall, the Manitoba estimates are greater than or equal to Fraser Institute estimates in 73 percent of cases, and less than Fraser Institute estimates in 27 percent of cases. In conjunction with the information about volatility provided by the Manitoba data, and the timing differences between the estimates, it would seem that the two methods produce estimates of waiting times that are more or less consistent.

Bellan *et al.* (2001) reported on the Manitoba Cataract Waiting List Program, recording a median wait of 28.9 weeks for cataract surgery in November 1999 (The Fraser Institute recorded a median wait of 12.0 weeks that year; see Zelder with Wilson, 2000). Bellan *et al.* report that estimates of waiting times for cataract surgery by both The Fraser Institute and the Manitoba Centre for Health Policy and Evaluation have been too low.

Tu *et al.* (2005) obtained median waiting times for 12 health services delivered in Ontario in 2003-04, 11 of which can be compared with waiting times estimated by The Fraser Institute (MRI, CT, Hip and Knee Replacement, Cataract Surgery, Angiography, Angioplasty, Elective Bypass Surgery, Hysterectomy, Radical Prostatectomy, and Mastectomy). Chart 9 shows a comparison of the data published by Tu *et al.* for fiscal year 2003-04 with wait times published by The Fraser Institute in both 2003 and 2004. For 14 of the 22 comparisons (11 procedures over two years), the Fraser Institute’s measures of waiting times in Ontario are equal to or shorter than those measured by ICES.

Mayo *et al.* (2001) studied the waiting time between initial diagnosis and first surgery for breast cancer (mastectomies and lumpectomies) in Quebec between 1992 and 1998. Their finding was that there was a sig-

Chart 9: Waiting Times—Difference between Institute for Clinical Evaluative Sciences (Ontario) and The Fraser Institute



Note: Wait times for Angiography and Angioplasty were measured separately by Tu *et al.*, while they are measured in a single category “Angiography/Angioplasty” by The Fraser Institute.

*The median wait time for this procedure was measured by ICES in days. This wait time has been divided into a 7-day week for comparison with the wait time produced by The Fraser Institute.

Source: Tu *et al.* (2005) and The Fraser Institute’s national waiting list surveys.

nificant increase in waiting time during that period. As initial diagnosis is not necessarily at the time of referral by the general practitioner, the time segment is not necessarily comparable to the Institute’s measurement of the total wait time between the general practitioner referring the patient and treatment. Nonetheless, Mayo *et al.* found the wait time in 1992 to be longer than the Institute’s estimate, and in 1998, they found the wait time to be considerably longer (10.3 versus 5.0 weeks).

Bell *et al.* (1998) surveyed the two largest hospitals in every Canadian city of 500,000 or more² in 1996-97 to learn their waiting times for 7 procedures, many of which were diagnostic. Among these, the Institute also collected three: magnetic resonance imaging, colonoscopy, and knee replacement. In all three cases, the median waiting times found by Bell *et al.* exceeded

the Institute’s Canada-wide waiting times (for these, see Ramsay and Walker, 1997).

Liu and Trope (1999) assessed the length of wait for selected ophthalmological surgeries in Ontario in late 1997. The Institute’s survey also tracks three of these procedures—cataract extraction, corneal transplant, and pterygium excision. In all three cases, the Institute figures (see Ramsay and Walker, 1998) were lower than the values independently derived by Liu and Trope.

In summary, 46 independent waiting time estimates exist for comparison with recent Institute figures. In 31 of 46 cases, the Institute figures lie below the comparison values. In only 12 instances does the Institute value exceed the comparison value, and in three cases they are identical. This evidence strongly suggests that the Institute’s

measurements are not biased upward, but, if anything, may be biased downward, understating actual waiting times.

Further confirmation of the magnitude of Canadian waiting times can be derived from 5 international comparative studies (the first 4 of which are noted above). Coyte *et al.* (1994) found that in the late 1980s, Canadians waited longer than Americans for orthopaedic consultation (5.4 versus 3.2 weeks) and for surgery post-consultation (13.5 versus 4.5 weeks). Collins-Nakai *et al.* (1992) discovered that in 1990, Canadians waited longer than Germans and Americans, respectively, for cardiac catheterization (2.2 months, versus 1.7 months, versus 0 months), angioplasty (11 weeks, versus 7 weeks, versus 0 weeks), and bypass surgery (5.5 months, versus 4.4 months, versus 0 months). Another study of cardiac procedures, by

2 Although not identified by name, this list presumably consisted of Montreal, Toronto, Winnipeg, Calgary, Edmonton, and Vancouver.

Carroll *et al.* (1995), revealed that in 1992 Canadians generally waited longer for both elective and urgent coronary artery bypass than did Americans (whether in private or public Veterans' Administration hospitals) and Swedes, and longer than Americans (in either hospital type) for either elective or urgent angiography. At the same time, Canadians had shorter waits than the British for elective and urgent bypasses and angiographies, and shorter waits than Swedes for both types of angiographies. Finally, Jackson, Doogue, and Elliott (1998) compared waiting times for coronary artery bypass between New Zealand in 1994-95 and Ontario in the same period, using data from Naylor *et al.* (1995). They found that the New Zealand mean and median waiting times (232 and 106 days, respectively) were longer than the Canadian mean and median (34 and 17 days, 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, patients with non-cardiac conditions that require immediate care replace some cardiac surgery candidates. 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 increasing the funding for it.

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 6-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. Throughout Canada in 2005, an average of 2.5 percent of cardiac patients inquired about receiving treatment in another province, while 2.5 percent of patients asked about treatment in another country. From these inquiries, 0.8 percent of all patients received treatment in another province and 0.6 percent received treatment in another country (The Fraser Institute, national hospital waiting list survey, 2005).

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

Since 1993, The Fraser Institute 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 9-level prioritization system developed in Ontario. Other provinces have a 4-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 using these categories should, therefore, be made tentatively, while recognizing that this survey provides the only comprehensive comparative data available on the topic.

As noted earlier, efforts were made again this year to verify the cardiovascular surgery survey results using data from provincial health ministries and from provincial cardiac agencies. These data are noted in the tables.

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 median waiting time for urgent, rather than elective, patients. The median waiting time for urgent patients was chosen over the emergent or elective medians because it is the intermediate of the three measures.

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 9 categories of treatment priority. For comparative purposes, it was necessary to collapse their 9 priority categories down to the 3 used in this study. Once this was done, their findings suggested that emergent patients should be operated on within 3 days (0.43 weeks). This year's median wait times for Saskatchewan, Nova Scotia, and Newfoundland fall outside this range (see table 5h). 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 6 weeks. By comparison, the longest median wait for urgent cardiac surgery reported in 2005 was 6.0 weeks (Prince Edward Island) (see tables 4 and 5h). Finally, the Ontario panel suggested that elective surgeries be performed within a period of 24 weeks. Newfoundland currently falls outside of this time frame (see tables 4 and 5h).

Prior to 1998, this Ontario panel's waiting-time estimates were used as the measure of the clinically reasonable wait for patients requiring cardiovascular surgery. Since 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 cardiovascular specialists to be much less tolerant of long waits than the Ontario panel. This year's respondents felt that urgent patients should only wait 0.7 weeks for surgery (instead of 6 weeks), and that patients requiring elective cardiovascular surgery should only wait 4.2 weeks (instead of 24 weeks; see table 8).

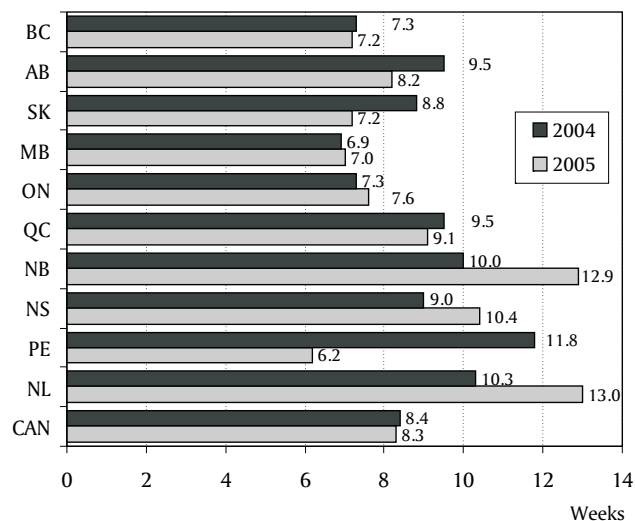
More recently, a group of Canadian physician associations known as the Wait Time Alliance for Timely

Health Care (WTA, 2005) published a set of medically reasonable wait times that can also be compared with physician responses to the *Waiting Your Turn* survey. The WTA suggests that patients should wait no longer than 6 weeks for an office consultation with a specialist for a scheduled case. This year's median waits for routine specialist consults in New Brunswick, Nova Scotia, and Newfoundland fall outside this range (see table 3). According to the WTA, urgent bypass surgeries should be completed within 14 days and scheduled (elective) bypass surgeries within 6 weeks (WTA, 2005, p. 3). By comparison, the longest median wait for urgent bypass surgery reported in 2005 was 2.0 weeks (British Columbia, Alberta, and Saskatchewan), while wait times for elective bypass surgery in British Columbia, Alberta, New Brunswick, and Newfoundland are beyond the recommended wait time (see table 5h). The WTA also recommends that urgent and scheduled (elective) valvular surgeries should be completed within 14 days and 6 weeks respectively (WTA, 2005, p. 3). Again, the longest waiting time reported for urgent operations on the valves and septa of the heart in 2005 was 2.0 weeks (British Columbia, Alberta, and Saskatchewan), while wait times in British Columbia, Alberta, New Brunswick, and Newfoundland are beyond the recommended wait time for elective operations (see table 5h). Finally, the WTA recommended maximum wait times of less than 14 days and less than 6 weeks for urgent and elective pacemaker operations respectively. Wait times reported for 2005 in New Brunswick, Nova Scotia and Prince Edward Island are currently 14 days or longer for urgent pacemaker operations, while waiting times reported for 2005 in British Columbia, New Brunswick, and Prince Edward Island are 6 weeks or longer for elective operations (see table 5h).

Survey results: estimated waiting in Canada

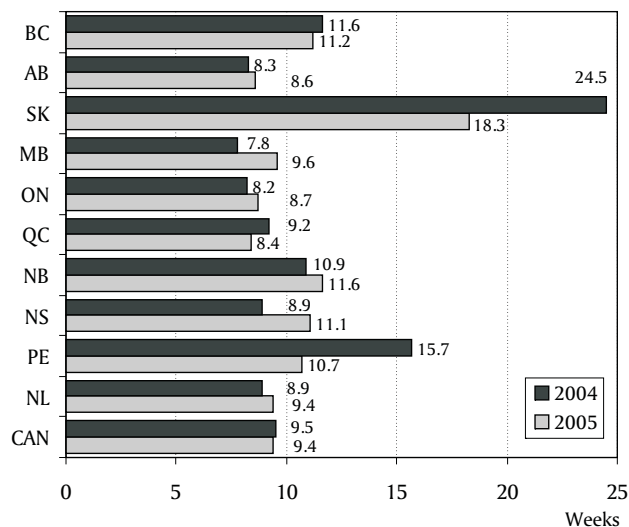
The total waiting time for surgery is composed of two segments: waiting after seeing a general practitioner before consultation with a specialist, and subsequently, waiting to receive treatment after the first consultation with a specialist. The results of the most recent survey from 2005 provide details, by province, of total waiting and of each segment.

Chart 10: Waiting By Province in 2004 and 2005: Weeks Waited from Referral by GP to Appointment with Specialist



Source: The Fraser Institute's national waiting list survey, 2005.

Chart 11: Waiting by Province in 2004 and 2005: Weeks Waited from Appointment with Specialist to Treatment



Source: The Fraser Institute's national waiting list survey, 2005.

Waiting time between general practitioner referral and specialist appointment

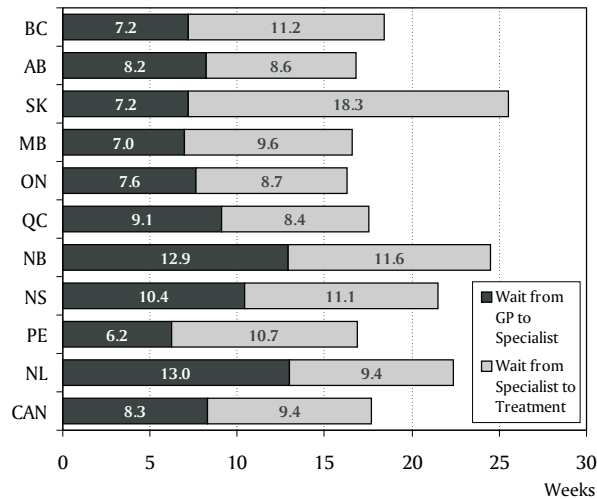
Table 3 indicates the median number of weeks that patients wait for initial appointments with specialists after referral from their general practitioners or from other specialists. For Canada as a whole, the waiting time to see a specialist, 8.3 weeks in 2005, is 124 per cent longer than in 1993, when it was 3.7 weeks (see graphs 1 and 2). The weighted medians, depicted in chart 10 and graph 1, reveal that Prince Edward Island has the shortest waits in the country for appointments with specialists (6.2 weeks), while Newfoundland has the longest (13.0 weeks). The waiting time to see a specialist has increased in 5 provinces since 2004, and has fallen in British Columbia, Alberta, Saskatchewan, Quebec, and Prince Edward Island. Looking at particular specialties, most waits for specialists' appointments are less than two months in duration (see table 3). However, there are a number of waiting times of 12 weeks or longer: to see a plastic surgeon in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, Nova Scotia, or Newfoundland; to see a gynaecologist in Newfoundland; to see an ophthalmologist in Ontario, Quebec, New Brunswick, Nova Scotia, Prince Edward Island, or Newfoundland; to see

an otolaryngologist in Nova Scotia; to see a neurosurgeon in British Columbia, Alberta, Ontario, New Brunswick, or Newfoundland; to see an orthopaedic surgeon in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia, or Newfoundland; to see a urologist in Newfoundland; and to see an internal medicine specialist in New Brunswick.

Waiting time between specialist consultation and treatment

Tables 5a through 5l contain data on the time waited between specialist consultation and treatment for each of the 12 specialties surveyed, including subspecialty breakdowns for the different procedures contained under each specialty heading. These tables indicate that residents of all provinces surveyed wait significant periods of time for most forms of hospital treatment. While there are only short waits for some treatments, most procedures require waits of at least a month. The data in tables 5a through 5l are summarized in table 4 and chart 11 as weighted medians for each specialty, for each province, and for Canada. For Canada as a whole, the wait for treatment after having seen a specialist fell slightly in 2005 to 9.4 weeks, down 0.1 weeks from the 2004 level (9.5 weeks). This

Chart 12: Median Wait by Province in 2005: Weeks Waited from Referral by GP to Treatment



Note: Totals may not match sum of subtotals due to rounding.
Source: The Fraser Institute's national waiting list survey, 2005.

portion of waiting is 68 percent longer than in 1993, when the wait for treatment after having seen a specialist was 5.6 weeks (see graphs 3 and 4). Ranking the provinces according to the 2005 weighted medians indicates that the longest median wait for surgery after visiting a specialist occurs in Saskatchewan (18.3 weeks) and the shortest is in Quebec (8.4 weeks). Chart 11 illustrates the median waits for treatment by province. Among the specialties, the longest Canada-wide waits are for orthopaedic surgery (25.3 weeks), plastic surgery (20.9 weeks), and ophthalmology (13.1 weeks), while the shortest waits exist for urgent cardiovascular surgery (1.1 weeks), medical oncology (2.6 weeks), and radiation oncology (4.1 weeks) (see table 4).

Table 7 presents a frequency distribution of the median waits for surgery by province and by region. In all provinces, the wait for the majority of operations is less than 13 weeks. Prince Edward Island performs the highest proportion of surgeries within 13 weeks (82.4 percent), while Manitoba performs the highest proportion within 8 weeks (61.5 percent). Waits of 26 weeks or more are least frequent in Prince Edward Island (8.2 percent), and most frequent in Saskatchewan (33.3 percent).

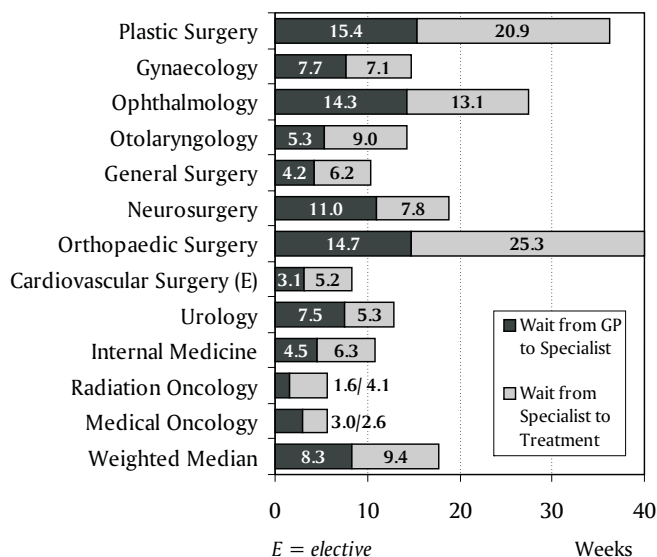
Table 6 compares the 2004 and 2005 waiting times for treatment. This year's study indicates an overall increase in the waiting time between consultation with a specialist and treatment in 6 provinces, with decreases in British Columbia (4%), Saskatchewan (25%), Quebec (9%), and Prince Edward Island (32%) (table 6 and chart 11). At the same time, between 2004 and 2005, the median wait increased by 4 percent in Alberta, 22 percent in Manitoba, 5 percent in Ontario, 6 percent in New Brunswick, 24 percent in Nova Scotia, and 5 percent in Newfoundland.

Total waiting time between general practitioner referral and treatment

While the data on these two segments of waiting time convey only partial impressions about the extent of health care rationing, information on the sum of those two segments, the total waiting time, provides a fuller picture. This overall wait records the time between the referral by a general practitioner and the time that the required surgery is performed. Table 2 and chart 12 present these total wait times for each province in 2005. For Canada as a whole, total waiting time fell slightly, from its previous value of 17.9 weeks in 2004 to 17.7 weeks in 2005—equaling the nation's performance as a whole in 2003. Among the provinces, total waiting time fell in 5 (British Columbia, Alberta, Saskatchewan, Quebec, and Prince Edward Island) between 2004 and 2005, but rose in the other 5. The shortest total waiting times in 2005 were recorded in Ontario (16.3 weeks), Manitoba (16.6 weeks), and Alberta (16.8 weeks). The longest total waits were in Saskatchewan (25.5 weeks), New Brunswick (24.5 weeks), and Newfoundland (22.3 weeks).

For Canada as a whole, the longest waits for treatment are in orthopaedic surgery, plastic surgery, and ophthalmology. The median waits for these specialties (table 2 and chart 13) are longer than 6 months: 40.0 weeks for orthopaedic surgery, 36.2 weeks for plastic surgery, and 27.4 weeks for ophthalmology. The shortest wait in Canada is for cancer patients being treated with chemotherapy. These patients wait approximately 5.5 weeks to receive treatment.

Chart 13: Median Wait by Specialty in 2005: Weeks Waited from Referral by GP to Treatment

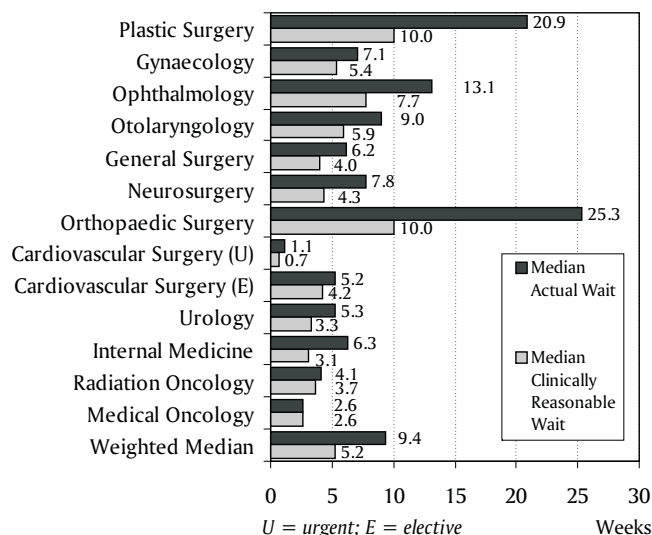


Note: Totals may not match sum of subtotals due to rounding.
Source: The Fraser Institute's national waiting list survey, 2005.

Clinically reasonable waiting times

When asked to give a clinically reasonable waiting time for the various procedures, specialists generally indicate a period of time substantially shorter than the median number of weeks patients were actually waiting for treatment (see tables 9a through 9l). Table 8 summarizes the weighted median reasonable waiting times for all specialties surveyed. These weighted medians were calculated in the same manner as those in table 4. Eighty-five percent of the actual weighted median waiting times (in table 4) are greater than the clinically reasonable weighted median waiting times (in table 8). For example, the median wait for plastic surgery in British Columbia is 24.2 weeks. A clinically reasonable length of time to wait, according to specialists in British Columbia, is 9.9 weeks. In Ontario, the actual time to wait for an ophthalmological procedure is 16.1 weeks, whereas a wait of 6.8 weeks is considered to be clinically reasonable. Table 10 summarizes the differences between the median reasonable and median actual wait for specialties.

Chart 14: Median Actual Wait Versus Median Clinically Reasonable Wait by Specialty for Canada: Weeks Waited from Appointment with Specialist to Treatment in 2005



Source: The Fraser Institute's national waiting list survey, 2005.

Chart 14 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 orthopaedic surgery, where the actual waiting time is 15.3 weeks longer than what is considered to be reasonable by specialists.

Number of procedures for which people are waiting

As a result of discussions with representatives from the Saskatchewan Department of Health in 2002, as discussed in the 12th edition of *Waiting Your Turn*, counts of the numbers of patients waiting for surgery have been replaced with the numbers of procedures for which patients are waiting. Although there is considerable evidence from provinces outside Saskatchewan that the previous assumption—that one procedure is a good proxy for one patient waiting—is sound, evidence from Saskatchewan suggests that “procedures for which people are waiting” is a description that better reflects The Fraser Institute’s methodology,

which was also altered in 2003 due to continued concerns with the estimated counts for Saskatchewan (see the section in this Bulletin entitled: “Verification of current data with governments”). As a result, these numbers should be interpreted with caution, especially for Saskatchewan. Although this cautionary note applies to all estimates of procedures for which people are waiting, there do not appear to be significant systematic differences between the numbers of procedures for which people are waiting estimated in this edition of *Waiting Your Turn* and counts of patients waiting provided to us by provincial ministries other than Saskatchewan.

Tables 13a through 13l estimate the numbers of procedures for which people are waiting for the specific procedures comprising each of the 12 specialties. 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 procedures for which people are waiting. Consequently, table 14 presents the numbers on a population-adjusted basis (per 100,000). This illustrates population-adjusted differences that are not apparent from the raw totals. For example, in Ontario, there are 9,077 gynaecology procedures for which people are waiting, while there are only 3,120 waited for in Alberta (see table 12). However, when the calculation is adjusted for population, a higher proportion of the population is waiting in Alberta: 99 procedures per 100,000 people there, versus 74 procedures per 100,000 people in Ontario (see table 14). Tables 12 and 14 provide summaries of estimated numbers of procedures for which people are waiting.

Table 15 compares the numbers of procedures for which people were waiting in 2004 with those in 2005. It should be noted that the procedure counts on which the estimates for New Brunswick are based are now classified using the ICD-10/CCI data standard, while the procedure counts employed for New Brunswick in 2004, due to a later adoption of the new data standard, were estimated on a pro-rated basis using hospitalization counts data from CIHI for 1999-2000. Thus, these changes should be interpreted with caution for New Brunswick in this changeover year. In four provinces, the estimated number of procedures for which people are waiting decreased between 2004 and 2005. The

estimated number of procedures for which people are waiting in Canada as a whole also fell, from 815,663 in 2004 to 782,936 in 2005, a 4 percent decrease. As a percentage of the population, 2.48 percent of Canadians were waiting for treatment in 2005,³ varying from a low of 1.87 percent in Prince Edward Island to a high of 5.32 percent in Saskatchewan.

Health expenditures and waiting times

Given the variation in waiting time across the provinces, it is natural to ask whether governments in 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 2) for the years 1993 through 1998 were taken from those 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 other differences across provinces such as the percentage of elderly, per capita disposable income, the party in power, and the frequency of health sector strikes) had shorter waiting times. The measure of spending used was real (i.e., adjusted for differences in health costs over time and across provinces) per capita total government spending on health care. The analysis revealed that provinces that spent more on health care per person had neither shorter nor longer weighted median waiting times than provinces that spent less. In addition, provinces that spent more had no higher rates of surgical specialist services (consultations plus procedures) and lower rates of procedures and major surgeries (for the complete results of this analysis, see Zelder, 2000b). A follow-up study in 2003 using a similar methodology found that increased health expenditures were actually correlated with *increases* in waiting times, unless those spending increases were targeted to doctors or pharmaceutical expenditures (Esmail, 2003).

These findings, that additional spending has no positive effect on waiting or service provision, must imply that spending increases are being absorbed entirely by wage increases or by administrative expenses. This result, while surprising at first, becomes more understandable when one considers the environment in

3 On the assumption that one procedure is equivalent to one patient.

Chart 15: Canadian Doctors, Medical Technology, and Health Spending Relative to the Universal Access Countries of the OECD,¹ Age-Adjusted,² 2002

Comparison	Canadian Value	OECD Average	Canadian Rank	Number of Countries
Doctors per 1,000 Population	2.3	2.9	24	27
CT Scanners per Million Population	10.8	19.0	17	21
MRI Scanners per Million Population	4.7	7.9	13	22
Lithotriptors per Million Population	0.4	3.4	16 (tie)	16
Mammographs per Million Population	21.4	22.4	7	12
National Health Expenditure as a Percent of GDP	10.7	8.5	3	27

¹That is, not including the United States or Mexico.

²All values have been age adjusted to account for the fact that the Canadian population is relatively young when compared to other developed nations with universal access health systems (Esmail and Walker, 2005).

Source: Esmail and Walker, 2005.

which Canadian health care is provided. Canadian health care is an enterprise highly dominated by government. Indeed, in 2004, the fraction of total Canadian health spending attributable to governments was 69.9 percent (OECD, 2005). A substantial body of economic research demonstrates that governments are almost always less effective providers of goods and services than private firms. Borchering *et al.*'s (1982) 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. Megginson and Netter, in their comprehensive review of privatization (2001), concluded that privately-owned firms are more efficient and profitable than comparable public sector firms. This pattern was replicated in the context of hospital care, where Zelder (2000a) found that the majority of studies comparing for-profit and government-run hospitals indicated that for-profits had lower costs. Consequently, the revelation that higher spending appears to produce no improvement in waiting time is entirely consistent with this literature. 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 15 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 was ranked third in health spending amongst the universal-access, public-health-care-system countries in the OECD in 2002 after accounting for the age of the Canadian population (Esmail and Walker, 2005), the age-adjusted availability of medical technology (per million people) in Canada ranks well below that of many other OECD nations. Specifically, Canada exhibits low availability of computed tomography (CT) scanners, lithotripters (which break up kidney stones), and magnetic resonance imagers (MRIs). There are, of course, differences in access to technology among the provinces as well (Ramsay and Esmail, 2004).

This year's study examined the wait for various diagnostic technologies across Canada. Chart 16 displays the median number of weeks patients must wait for access to a CT, MRI, or ultrasound scanner. The median wait for MRI was shorter in 2005 than in 2004, while wait times for CT scans and ultrasound increased. The median wait for a CT scan across Canada was 5.5 weeks. The shortest wait for computed tomography was in New Brunswick, Nova Scotia, and Prince Edward Island (4.0 weeks), while the longest wait occurred in Saskatchewan (8.0 weeks). The median wait for an MRI across Canada was 12.3 weeks. Prince Edward Island patients waited the least amount of time for an MRI (5.0 weeks), while Newfoundland residents waited longest (36.0 weeks). Finally, the median wait for ultrasound was 3.4 weeks across Canada. Alberta and Ontario displayed the shortest wait (2.0 weeks) while

Chart 16: Waiting for Technology—Weeks Waited to Receive Selected Diagnostic Tests in 2003, 2004, and 2005

Province	CT-Scan			MRI			Ultrasound		
	2005	2004	2003	2005	2004	2003	2005	2004	2003
British Columbia	5.0	5.5	6.0	12.0	12.0	12.0	3.0	2.5	2.5
Alberta	5.5 ¹	6.0	6.0	10.0 ²	12.0	12.0	2.0	2.0	2.8
Saskatchewan	8.0	8.0	6.8	24.0	25.0	20.0	2.3	2.8	2.0
Manitoba	6.0 ³	6.0	7.0	10.0 ⁴	11.0	10.0	6.0 ⁵	8.0	8.0
Ontario	6.0	5.0	5.0	11.5	12.0	10.0	2.0	2.0	2.0
Quebec	5.0	5.0	6.0	12.0	12.0	15.0	5.0	4.0	6.0
New Brunswick	4.0	4.5	4.0	10.0	7.0	8.0	4.0	4.0	4.0
Nova Scotia	4.0	4.0	4.0	9.0	12.0	24.0	4.0	3.5	3.0
PEI	4.0	9.3	8.0	5.0	6.0	12.0	5.0	8.0	6.0
Newfoundland	5.5	4.3	4.0	36.0	33.5	24.0	9.0	8.5	6.0
Canada	5.5	5.2	5.5	12.3	12.6	12.7	3.4	3.1	3.6

¹Alberta Health and Wellness reports a median wait time of 3 weeks for CT scans for the 90 days preceding April 30, 2005. 14,162 patients were waiting for CT scans at April 30.

²Alberta Health and Wellness reports a median wait time of 7 weeks for MRI scans for the 90 days preceding April 30, 2005. 18,797 patients were waiting for MRI scans at April 30.

³Manitoba Health web site reports an average waiting time of 10 weeks for elective CT scans for the month of May, 2005.

⁴Manitoba Health web site reports an average waiting time of 17 weeks for elective MRI scans for the month of May, 2005.

⁵Manitoba Health web site reports an average waiting time of 13 weeks for elective ultrasound scans for the month of May, 2005.

Newfoundlanders, at 9.0 weeks, waited the longest for ultrasound.

Conclusion

The 2005 *Waiting Your Turn* survey indicates that waiting times for medical treatment in Canada have fallen slightly from 2004, but remain at a very high level historically. 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 their patients were experiencing were not acceptable.

Patients would also prefer earlier treatment, according to this year's survey data. On average, in all specialties, only 7.4 percent of patients are on waiting lists because they requested a delay or postponement of their treatment. The responses range from a low of 5.0 percent of internal medicine patients requesting a

delay of treatment, to a high of 10.6 percent of gynaecology 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 otolaryngology, general surgery, plastic surgery, and gynaecology. Radiation oncology and internal medicine patients are the most anxious to receive treatment (The Fraser Institute, national hospital waiting list survey, 2005).

Yet the disturbing trend of growing waiting lists in most provinces, documented here, implies that patients seeking treatment 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, and crucial medical resources priced and allocated by governments—prospects for improvement are dim. Only substantial reform of that regime is likely to alleviate the medical system's most curable disease—waiting times that are consistently and significantly longer than physicians feel is clinically reasonable.

Selected Graphs

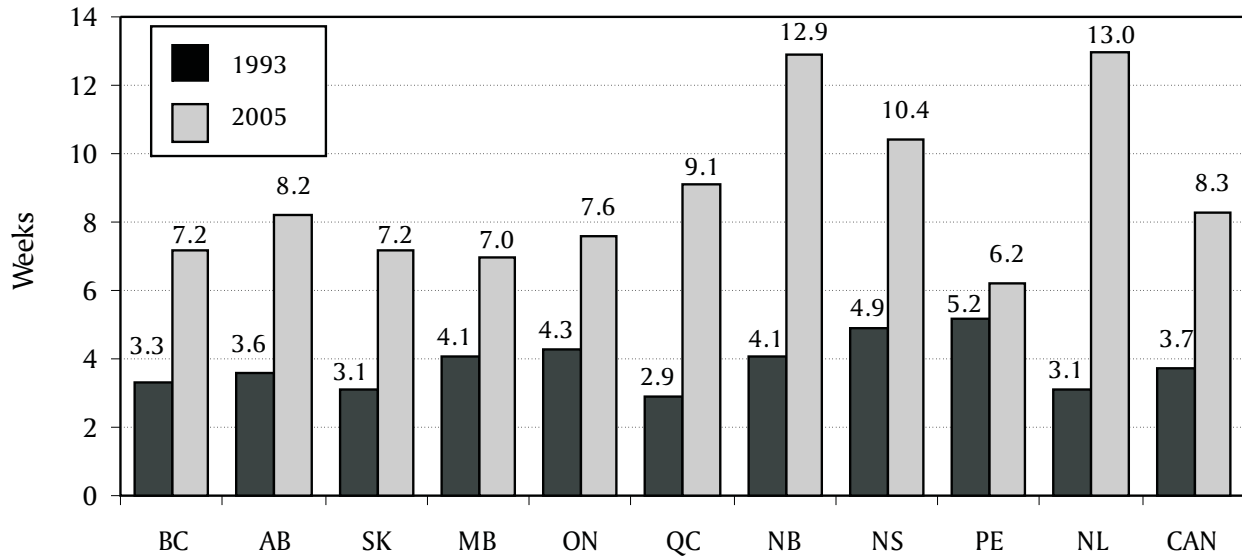
Graphs 1–6: Median Actual Waiting Times, 1993 and 2005

Graphs 7–8: Median Reasonable Waiting Times, 1994 and 2005

Graphs 9–19: Actual versus Reasonable Waiting Times, 1994 through 2005, by Province

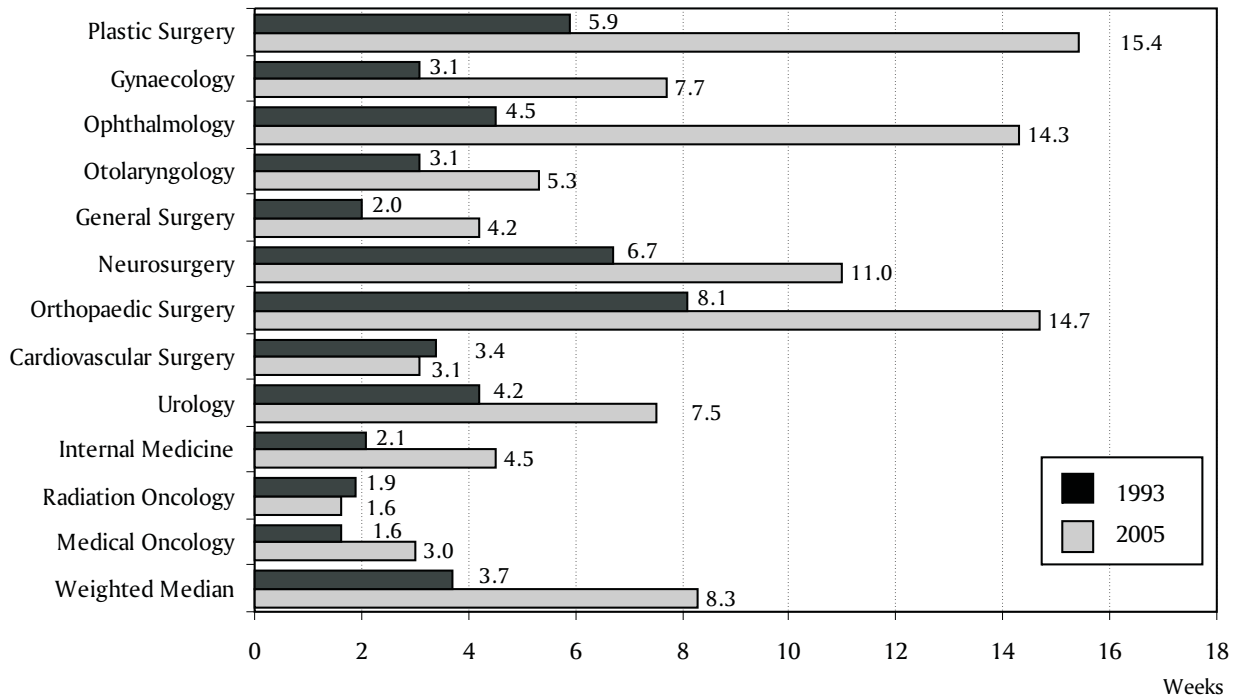
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Graph 1: Median Wait Between Referral by GP and Appointment with Specialist, by Province, 1993 and 2005



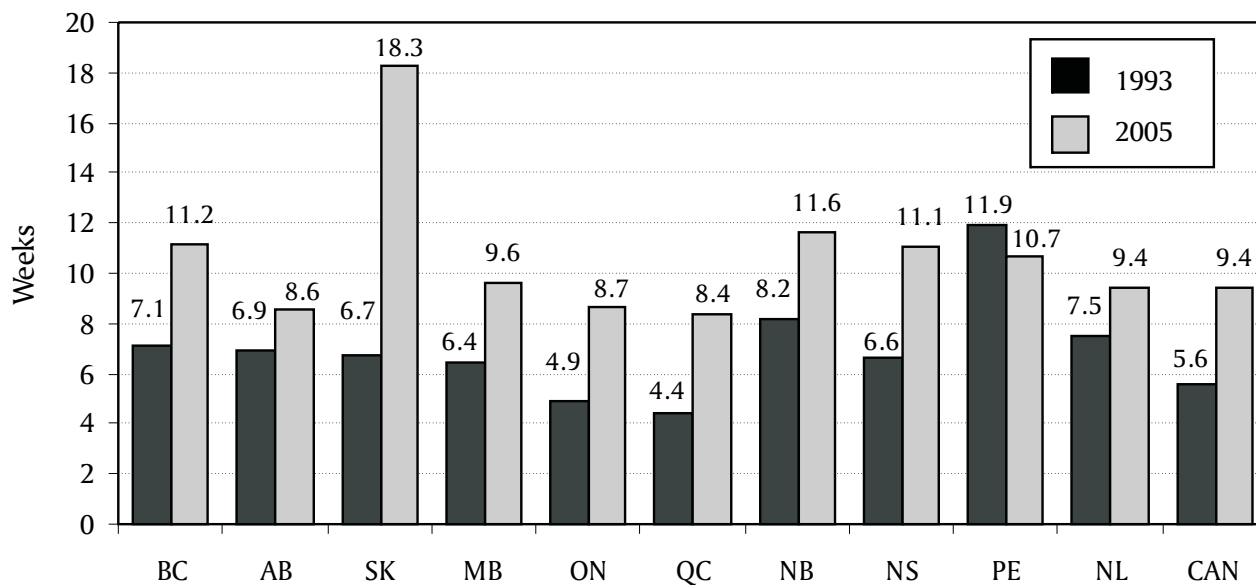
Source: The Fraser Institute's national waiting list survey, 2005; and Ramsay and Walker, 1997.

Graph 2: Median Wait between Referral by GP and Appointment with Specialist, by Specialty, 1993 and 2005



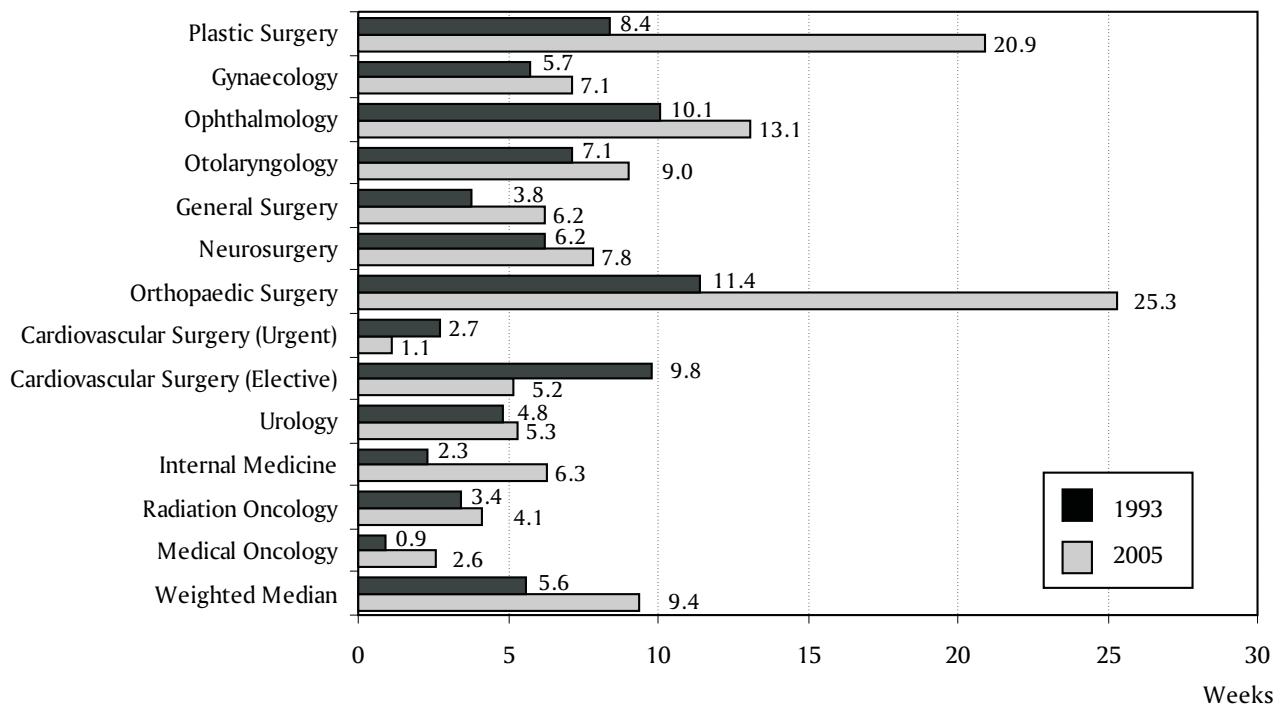
Source: The Fraser Institute's national waiting list survey, 2005; and Ramsay and Walker, 1997.

Graph 3: Median Wait between Appointment with Specialist and Treatment, by Province, 1993 and 2005



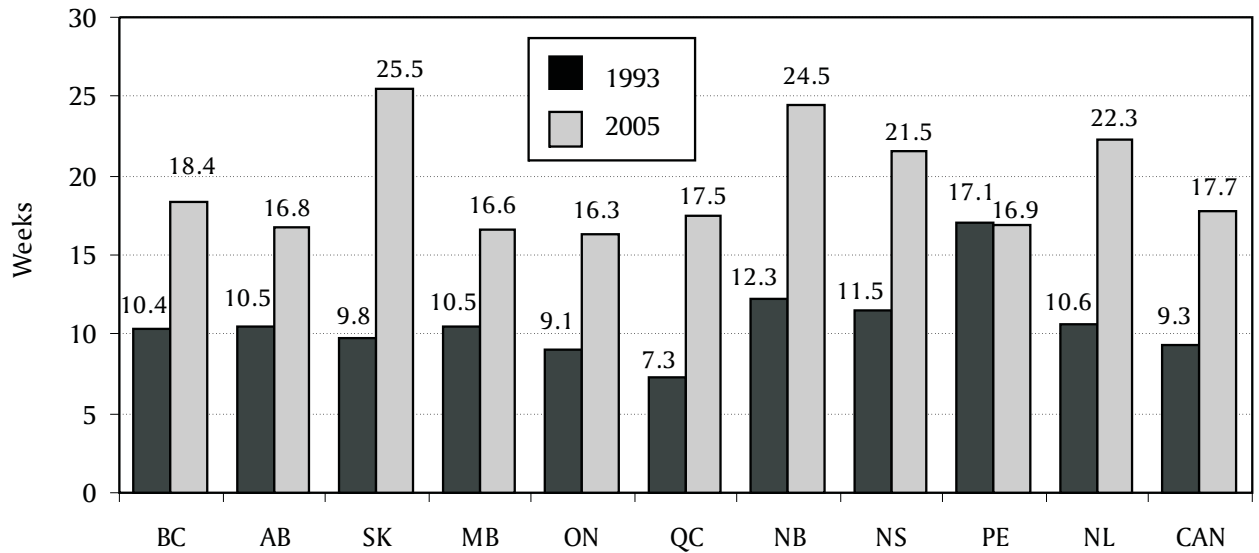
Source: The Fraser Institute's national waiting list survey, 2005; and Ramsay and Walker, 1997.

Graph 4: Median Wait between Appointment with Specialist and Treatment, by Specialty, 1993 and 2005



Source: The Fraser Institute's national waiting list survey, 2005; and Ramsay and Walker, 1997.

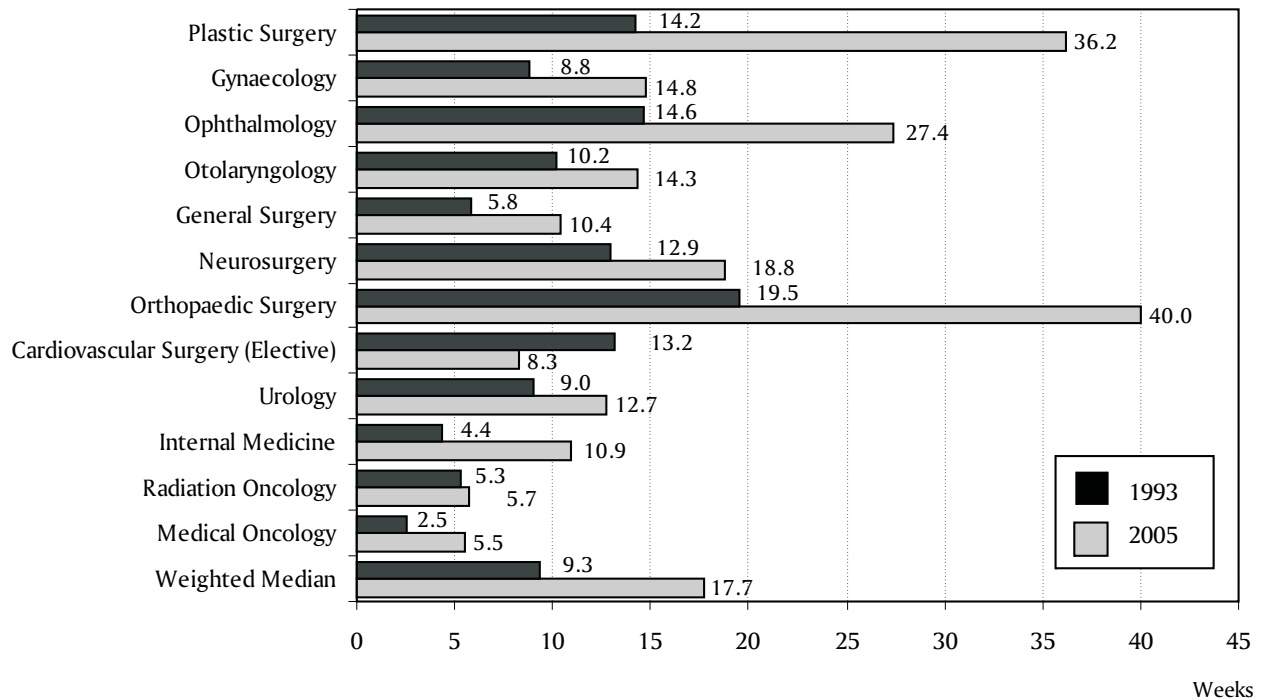
Graph 5: Median Wait between Referral by GP and Treatment, by Province, 1993 and 2005



Note: Totals may not equal the sum of the subtotals due to rounding.

Source: The Fraser Institute's national waiting list survey, 2005; and Ramsay and Walker, 1997.

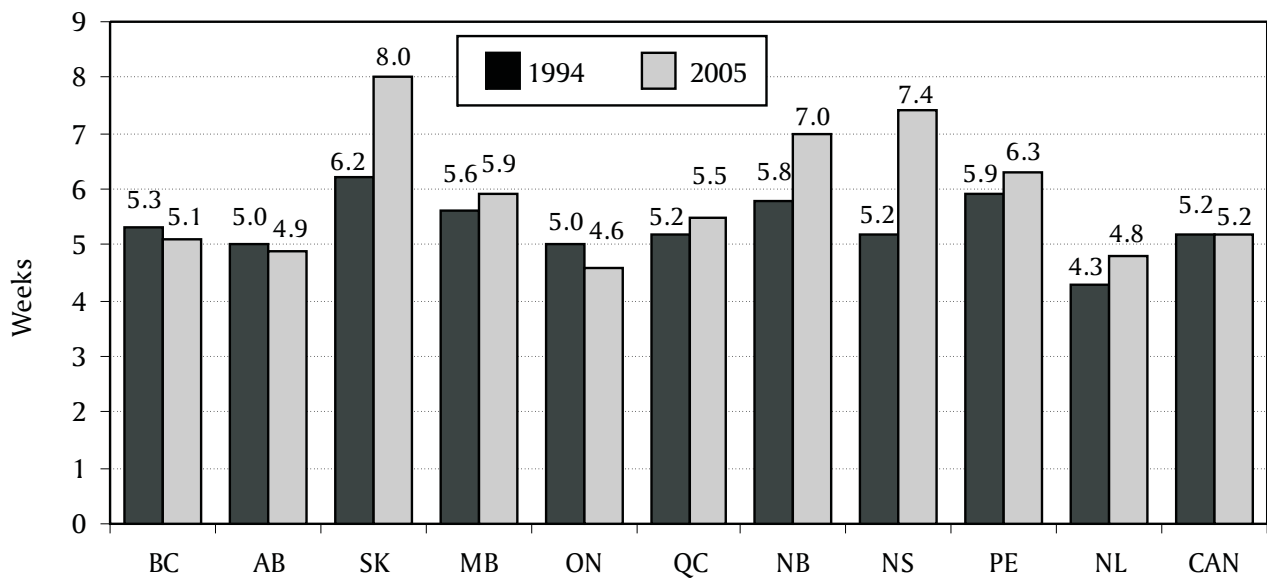
Graph 6: Median Wait between Referral by GP and Treatment, by Specialty, 1993 and 2005



Note: Totals may not equal the sum of the subtotals due to rounding.

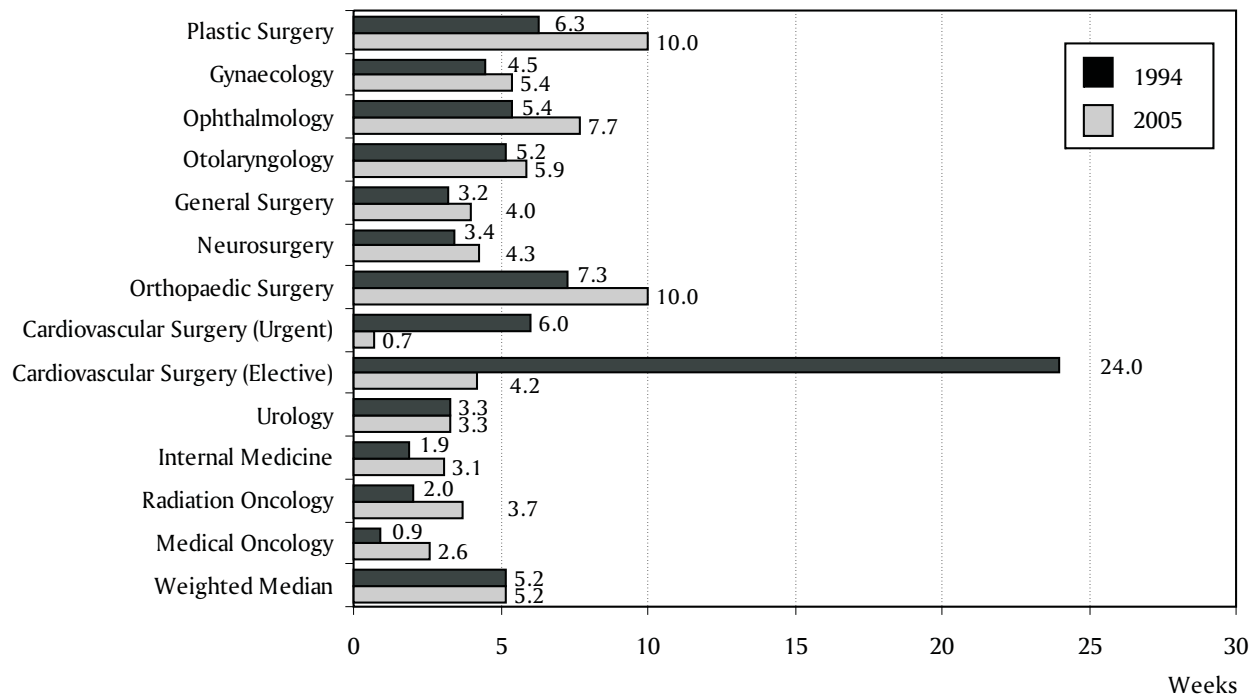
Source: The Fraser Institute's national waiting list survey, 2005; and Ramsay and Walker, 1997.

Graph 7: Median Reasonable Wait between Appointment with Specialist and Treatment, by Province, 1994 and 2005



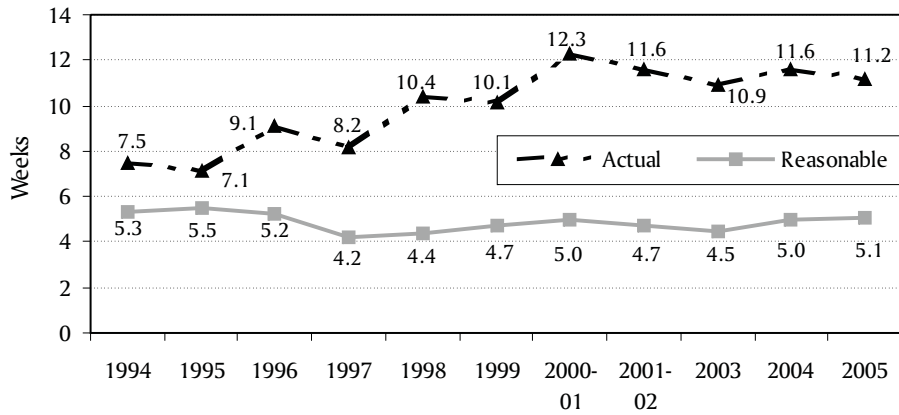
Source: The Fraser Institute's national waiting list survey, 2005; and Ramsay and Walker, 1997.

Graph 8: Median Reasonable Wait between Appointment with Specialist and Treatment, by Specialty, 1994 and 2005



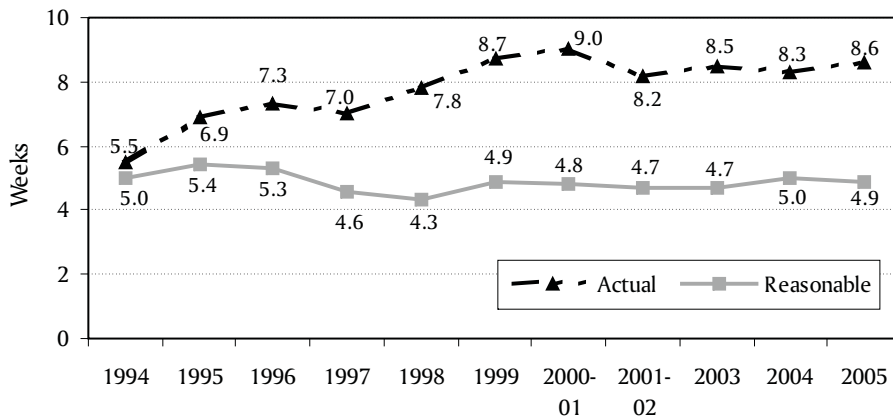
Source: The Fraser Institute's national waiting list survey, 2005; Ramsay and Walker, 1997; and Naylor *et al.*, 1991.

Graph 9: British Columbia—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2005



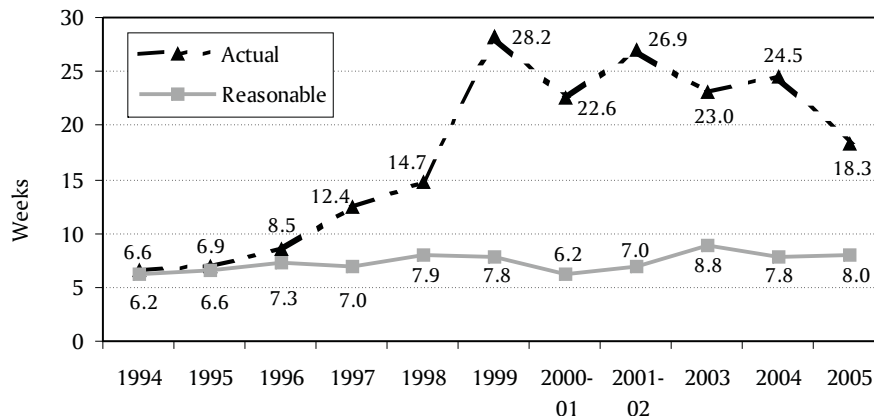
Source: The Fraser Institute's national waiting list surveys, 1995-2005.

Graph 10: Alberta—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2005



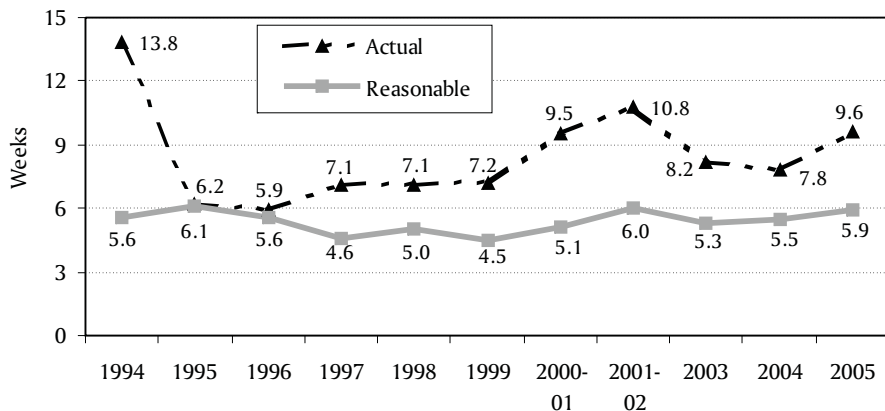
Source: The Fraser Institute's national waiting list surveys, 1995-2005.

Graph 11: Saskatchewan—Actual Versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2005



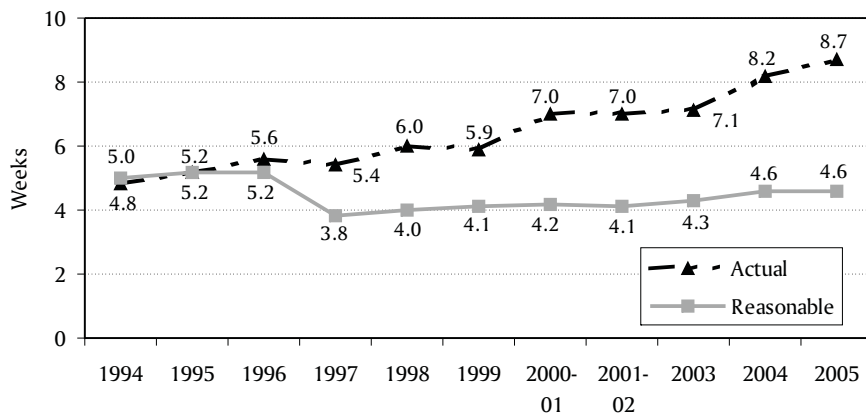
Source: The Fraser Institute's national waiting list surveys, 1995-2005.

Graph 12: Manitoba—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2005



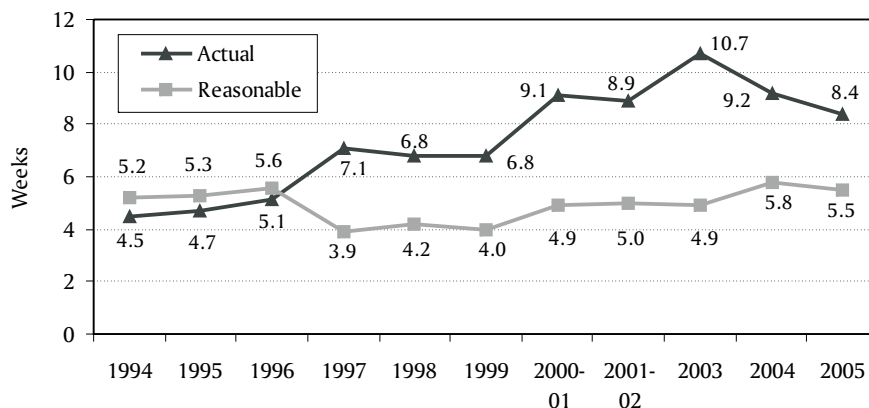
Source: The Fraser Institute's national waiting list surveys, 1995-2005.

Graph 13: Ontario—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2005



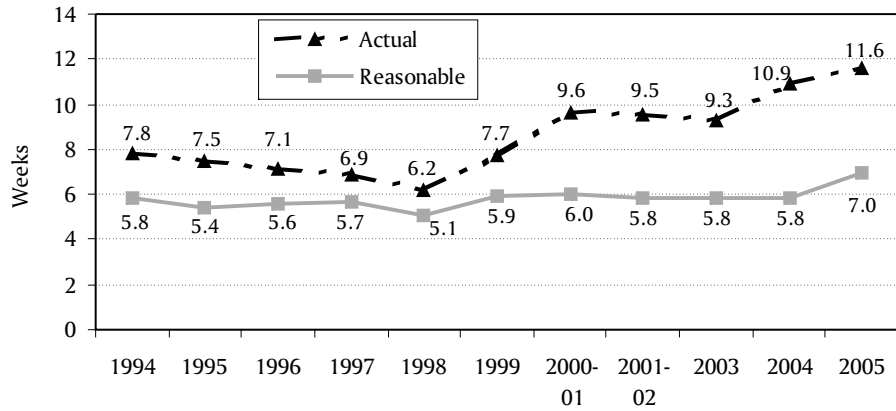
Source: The Fraser Institute's national waiting list surveys, 1995-2005.

Graph 14: Quebec—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2005



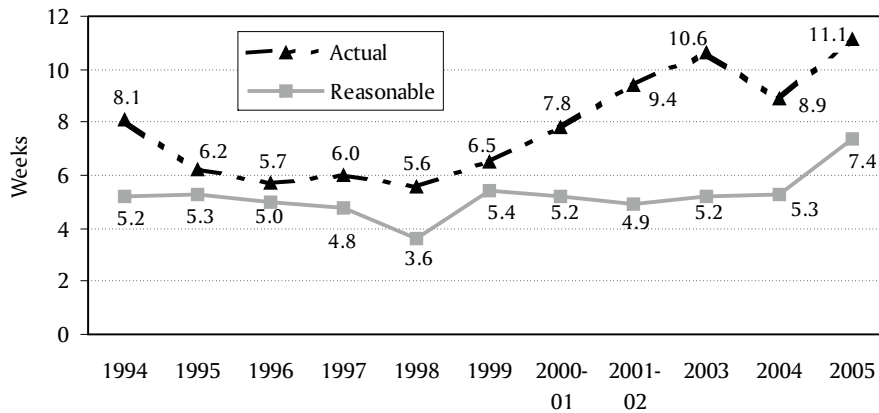
Source: The Fraser Institute's national waiting list surveys, 1995-2005.

Graph 15: New Brunswick—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2005



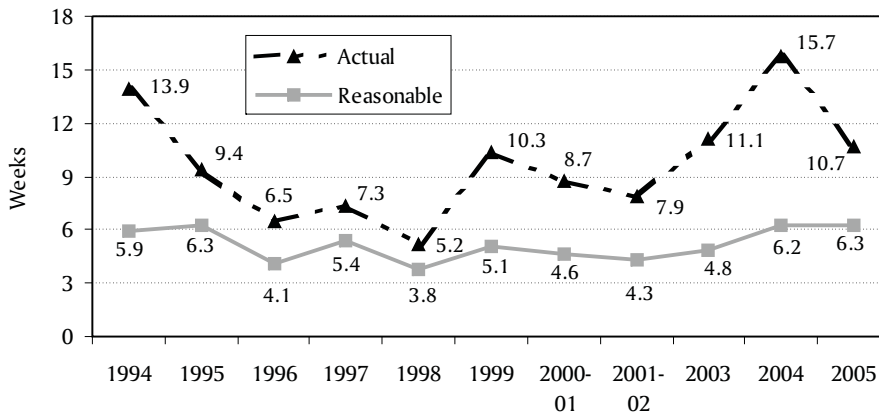
Source: The Fraser Institute's national waiting list surveys, 1995-2005.

Graph 16: Nova Scotia—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2005



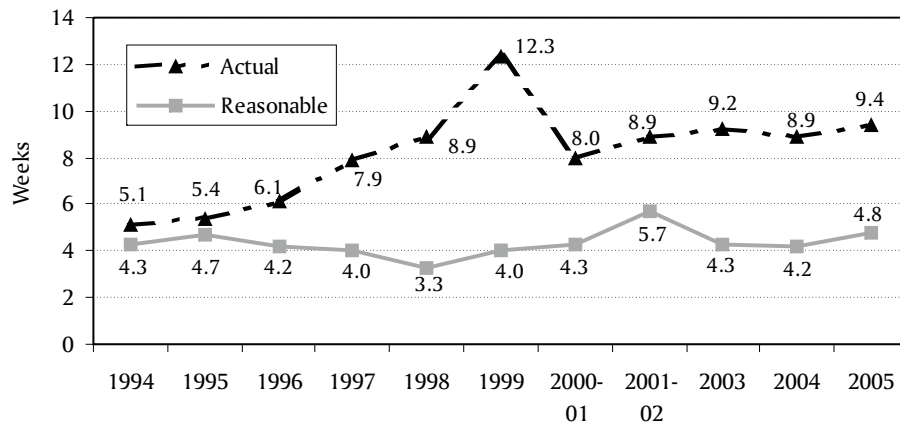
Source: The Fraser Institute's national waiting list surveys, 1995-2005.

Graph 17: Prince Edward Island—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2005



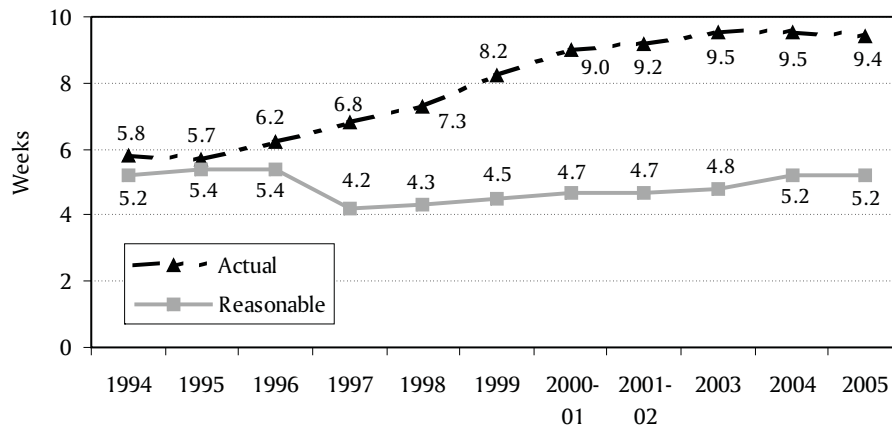
Source: The Fraser Institute's national waiting list surveys, 1995-2005.

Graph 18: Newfoundland—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2005



Source: The Fraser Institute's national waiting list surveys, 1995-2005.

Graph 19: Canada—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2005



Source: The Fraser Institute's national waiting list surveys, 1995-2005.

Selected Data Tables

Tables 1a–1c: Summary of Responses

Table 2: Median Total Expected Waiting Time from Referral by GP to Treatment, by Province and Specialty

Table 3: Median Patient Wait to See a Specialist after Referral from a GP, by Province and Specialty

Table 4: Median Patient Wait for Treatment after Appointment with Specialist, by Province and Specialty (Summary)

Tables 5a–5l: Median Patient Wait for Treatment after Appointment with Specialist, by Specialty

Table 6: Comparison of Median Weeks Waited to Receive Treatment after Appointment with Specialist, by Selected Specialties, 2004 and 2005

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Table 12: Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist, by Province and Specialty (Summary)

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Table 15: Comparison of Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist, by Selected Specialties, 2004 and 2005

Table 16a: Acute Inpatient Procedures, 2003-04

Table 16b: Same Day Procedures, 2003-04

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Table 1a: Summary of Responses, 2005—Response Rates (Percentages)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	55%	35%	46%	30%	40%	20%	31%	33%	100%	75%	37%
Gynaecology	28%	27%	29%	38%	25%	19%	31%	40%	33%	32%	25%
Ophthalmology	33%	40%	40%	46%	44%	27%	33%	26%	40%	38%	37%
Otolaryngology	41%	47%	86%	36%	40%	22%	64%	42%	0%	30%	36%
General Surgery	36%	24%	29%	25%	32%	16%	39%	40%	50%	22%	27%
Neurosurgery	54%	41%	57%	29%	33%	21%	43%	60%	—	67%	36%
Orthopaedic Surgery	48%	37%	50%	37%	41%	25%	45%	44%	33%	47%	38%
Cardiovascular Surgery	29%	46%	25%	33%	30%	23%	30%	25%	100%	40%	29%
Urology	42%	31%	20%	27%	37%	23%	44%	53%	0%	71%	34%
Internal Medicine	21%	19%	23%	17%	23%	18%	21%	26%	20%	22%	21%
Radiation Oncology	0%	23%	67%	33%	25%	28%	38%	22%	100%	33%	22%
Medical Oncology	20%	21%	—	0%	18%	18%	50%	63%	100%	75%	20%
Total	32%	29%	34%	28%	32%	21%	36%	36%	38%	36%	29%

Table 1b: Summary of Responses, 2005—Number of Responses

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	30	14	6	3	65	21	4	4	1	3	151
Gynaecology	46	35	10	18	146	71	10	19	2	6	363
Ophthalmology	49	32	8	11	161	70	7	11	2	5	356
Otolaryngology	28	17	6	5	79	39	9	8	0	3	194
General Surgery	58	29	10	14	158	68	13	18	3	5	376
Neurosurgery	15	9	4	2	21	12	3	6	—	2	74
Orthopaedic Surgery	70	39	12	13	157	70	13	12	1	7	394
Cardiovascular Surgery	14	12	3	3	40	22	3	4	1	2	104
Urology	28	12	2	4	79	32	8	9	0	5	179
Internal Medicine	54	42	13	18	157	69	8	20	2	6	389
Radiation Oncology	0	7	2	2	32	15	3	2	1	1	65
Medical Oncology	9	6	—	0	18	21	1	5	1	3	64
Total	401	254	76	93	1,113	510	82	118	14	48	2,709

Table 1c: Summary of Responses, 2005—Number of Questionnaires Mailed Out

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	55	40	13	10	161	103	13	12	1	4	412
Gynaecology	166	131	35	48	595	368	32	48	6	19	1,448
Ophthalmology	147	80	20	24	363	260	21	42	5	13	975
Otolaryngology	68	36	7	14	199	177	14	19	1	10	545
General Surgery	159	120	34	55	500	427	33	45	6	23	1,402
Neurosurgery	28	22	7	7	64	56	7	10	—	3	204
Orthopaedic Surgery	146	105	24	35	381	275	29	27	3	15	1,040
Cardiovascular Surgery	49	26	12	9	132	97	10	16	1	5	357
Urology	66	39	10	15	214	140	18	17	2	7	528
Internal Medicine	259	222	57	104	671	394	39	78	10	27	1,861
Radiation Oncology	49	30	3	6	130	54	8	9	1	3	293
Medical Oncology	44	29	—	5	102	118	2	8	1	4	313
Total	1,236	880	222	332	3,512	2,469	226	331	37	133	9,378

Table 2: Median Total Expected Waiting Time from Referral by GP to Treatment, by Specialty, 2005 (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	40.2	34.0	62.1	54.4	28.1	22.7	88.0	109.3	31.8	54.1	36.2
Gynaecology	14.0	17.9	20.1	12.7	14.0	14.3	18.4	14.5	13.5	16.1	14.8
Ophthalmology	18.8	16.4	38.6	20.7	30.1	27.8	35.2	24.1	39.0	45.7	27.4
Otolaryngology	14.7	18.3	49.1	11.9	12.6	9.6	21.0	21.8	—	6.2	14.3
General Surgery	12.6	9.4	13.0	5.7	9.7	9.9	12.8	14.0	6.3	22.4	10.4
Neurosurgery	21.1	17.8	18.5	11.1	20.2	14.9	45.8	19.4	—	17.1	18.8
Orthopaedic Surgery	49.9	52.7	53.1	49.0	34.4	32.3	34.0	54.2	34.5	23.7	40.0
Cardiovascular Surgery (Elective)	11.8	7.9	7.6	7.0	6.3	6.8	13.7	12.2	16.0	59.5	8.3
Urology	13.2	7.9	20.7	13.1	10.6	14.1	15.3	17.4	—	31.3	12.7
Internal Medicine	10.6	12.6	11.6	8.1	11.1	10.3	26.0	8.2	13.3	7.9	10.9
Radiation Oncology	—	8.5	10.3	5.7	5.0 ¹	5.5	5.1	3.7	7.1	5.0	5.7
Medical Oncology	2.5	6.5	—	—	6.0 ²	4.8	5.0	8.3	—	8.5	5.5
Weighted Median	18.4	16.8	25.5	16.6	16.3	17.5	24.5	21.5	16.9	22.3	17.7

Note: Totals may not equal the sum of subtotals due to rounding.

¹Cancer Care Ontario web site reports that in 11 facilities, median waiting times (referral to treatment) ranged from 3.9 to 11.7 weeks for breast cancer, from 1.4 to 8.4 weeks for gynaecologic cancer, from 1.0 to 4.1 weeks for lung cancer, from 0.4 to 8.3 weeks for head and neck cancer, and from 2.1 to 12.0 weeks for genitourinary cancers for the period April to June 2005.

²Cancer Care Ontario web site reports that in 11 facilities, median waiting times (referral to treatment) ranged from 3.6 to 9.1 weeks for breast cancer, from 1.7 to 9.6 weeks for gynaecologic cancer, from 2.0 to 9.1 weeks for head and neck cancer, and from 3.0 to 6.0 weeks for lung cancer for the period April to June 2005.

Table 3: Median Patient Wait to See a Specialist after Referral from a GP, by Specialty, 2005 (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	16.0	13.0	14.0	24.0	12.0	8.5	60.0	48.0	6.0	36.0	15.4
Gynaecology	6.0	11.0	5.0	5.5	8.0	8.0	5.0	6.0	9.0	12.0	7.7
Ophthalmology	8.0	8.0	11.0	10.0	14.0	16.0	24.0	14.0	12.0	36.0	14.3
Otolaryngology	4.0	10.0	4.0	3.0	5.0	4.0	8.0	14.0	—	1.5	5.3
General Surgery	5.0	4.0	3.3	2.0	4.0	4.0	7.5	6.0	2.0	8.0	4.2
Neurosurgery	12.0	12.0	10.0	6.9	12.0	8.0	28.0	9.0	—	12.0	11.0
Orthopaedic Surgery	16.0	26.0	16.0	16.0	12.5	12.0	12.0	19.0	8.0	12.0	14.7
Cardiovascular Surgery	3.0	2.0	4.0	3.0	2.8	3.0	6.5	8.0	4.0	8.0	3.1
Urology	6.0	4.5	7.5	10.5	7.0	8.0	8.0	10.0	—	23.0	7.5
Internal Medicine	4.0	4.0	4.0	4.0	5.0	4.3	12.0	4.0	7.5	4.0	4.5
Radiation Oncology	—	2.0 ¹	4.0	2.0	2.0	1.0	2.0	0.6	1.0	2.0	1.6
Medical Oncology	1.5	3.0 ¹	—	—	3.0	3.0	2.5	5.0	—	4.0	3.0
Weighted Median	7.2	8.2	7.2	7.0	7.6	9.1	12.9	10.4	6.2	13.0	8.3

¹Alberta Health and Wellness web site reports wait times of between 4 and 7 weeks for a radiation oncologist for breast cancer, between less than 1 and 3.5 weeks for a radiation oncologist for prostate cancer, and between 3 and 4 weeks for a medical oncologist for breast cancer at July 31, 2005.

Table 4: Median Patient Wait for Treatment after Appointment with Specialist, by Specialty, 2005 (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	Can
Plastic Surgery	24.2	21.0	48.1	30.4	16.1	14.2	28.0	61.3	25.8	18.1	20.9
Gynaecology	8.0	6.9	15.1	7.2	6.0	6.3	13.4	8.5	4.5	4.1	7.1
Ophthalmology	10.8	8.4	27.6	10.7	16.1	11.8	11.2	10.1	27.0	9.7	13.1
Otolaryngology	10.7	8.3	45.1	8.9	7.6	5.6	13.0	7.8	—	4.7	9.0
General Surgery	7.6	5.4	9.7	3.7	5.7	5.9	5.3	8.0	4.3	14.4	6.2
Neurosurgery	9.1	5.8	8.5	4.2	8.2	6.9	17.8	10.4	—	5.1	7.8
Orthopaedic Surgery	33.9	26.7	37.1	33.0	21.9	20.3	22.0	35.2	26.5	11.7	25.3
Cardiovascular Surgery (Urgent)	1.5	1.6	1.5	1.5	1.0	0.8	1.3	2.0	6.0	1.0	1.1
Cardiovascular Surgery (Elective)	8.8	5.9	3.6	4.0	3.5	3.8	7.2	4.2	12.0	51.5	5.2
Urology	7.2	3.4	13.2	2.6	3.6	6.1	7.3	7.4	—	8.3	5.3
Internal Medicine	6.6	8.6	7.6	4.1	6.1	6.1	14.0	4.2	5.8	3.9	6.3
Radiation Oncology	—	6.5	6.3	3.7	3.0	4.5	3.1	3.0	6.1	3.0	4.1
Medical Oncology	1.0	3.5	—	—	3.0	1.8	2.5	3.3	2.0	4.5	2.6
Weighted Median	11.2	8.6	18.3 ¹	9.6	8.7	8.4	11.6	11.1	10.7	9.4	9.4

¹Saskatchewan Surgical Care Network web site reports that 23 percent of patients in Saskatchewan waited less than 24 hours, 22 percent waited between 24 hours and 3 weeks, 11 percent waited between 3 and 6 weeks, 12 percent waited between 6 weeks and 3 months, 12 percent waited between 4 and 6 months, 10 percent waited between 7 and 12 months, 5 percent waited between 13 and 18 months, and 6 percent waited more than 18 months for non-emergent surgeries between October 2004 and March 2005. For an extensive explanation and wait times for individual procedures, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5a: Plastic Surgery (2005)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Mammoplasty	37.5	32.0	70.0	52.0	24.0	20.0	29.5	112.5	75.0	40.0
Neurolysis	12.0	12.0	16.5	24.0	12.0	12.0	14.0	13.0	12.0	8.0
Blepharoplasty	16.0	12.0	16.0	24.0	10.0	8.0	33.0	49.0	12.0	16.0
Rhinoplasty	16.0	12.0	52.0	18.0	12.0	12.0	33.0	50.0	12.0	46.0
Scar Revision	16.0	22.0	44.0	18.0	12.0	12.0	39.0	76.0	12.0	20.0
Hand Surgery	16.0	12.0	30.0	24.0	12.0	12.0	21.0	26.5	12.0	5.0
Craniofacial Procedures	20.0	8.5	12.0	6.0	12.0	26.0	44.0	23.0	—	3.5
Skin Cancer and other Tumors	6.0	3.8	9.0	14.0	6.0	4.0	7.0	2.8	12.0	2.5
Weighted Median	24.2 ¹	21.0 ²	48.1 ³	30.4	16.1	14.2	28.0	61.3	25.8	18.1

Note: Weighted median does not include craniofacial procedures or skin cancer and other tumors.

¹BC Ministry of Health web site reports a 5.6 week median wait time for plastic surgery for the three months ending May 31, 2005. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness reports a 6 week median wait for non-urgent plastic surgery for patients served in the 90 days preceding April 30, 2005.

³Saskatchewan Surgical Care Network web site reports that 23 percent of patients in Saskatchewan waited less than 24 hours, 17 percent waited between 24 hours and 3 weeks, 6 percent waited between 3 and 6 weeks, 10 percent waited between 6 weeks and 3 months, 13 percent waited between 4 and 6 months, 13 percent waited between 7 and 12 months, 7 percent waited between 13 and 18 months, and 11 percent waited more than 18 months for non-emergent plastic and reconstructive surgery between October 2004 and March 2005. For an extensive explanation and wait times for individual procedures, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5b: Gynaecology (2005)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Dilation & Curettage	4.0	4.5	5.0	5.0	4.0	4.0	6.0	7.0	2.8	2.5
Tubal Ligation	10.0	8.0	24.0	8.0	6.0	8.0	16.0	8.0	4.8	4.5
Hysterectomy (Vaginal/Abdominal)	12.0	10.0	20.0	7.5	8.0	8.0	16.0	10.0	5.8	4.0
Vaginal Repair	12.0	10.0	26.0	7.5	8.0	8.5	16.0	11.0	5.8	6.0
Tuboplasty	12.0	9.5	38.5	16.0	8.0	12.0	20.0	18.5	—	4.0
Laparoscopic Procedures	8.0	8.0	11.5	6.0	6.5	6.0	12.0	8.0	4.8	6.5
Hysteroscopic Procedures	6.0	7.0	8.0	6.0	6.0	6.5	9.0	8.0	3.0	5.0
Weighted Median	8.0 ¹	6.9 ²	15.1 ³	7.2	6.0	6.3	13.4	8.5	4.5	4.1

¹BC Ministry of Health web site reports a 4.0 week median wait time for gynaecology for the three months ending May 31, 2005. For an extensive explanation, please refer to "Verification of current data with governments—British Columbia."

²Alberta Health and Wellness reports a 7 week median wait for non-urgent gynaecological surgery for patients served in the 90 days preceding April 30, 2005.

³Saskatchewan Surgical Care Network web site reports that 24 percent of patients in Saskatchewan waited less than 24 hours, 26 percent waited between 24 hours and 3 weeks, 14 percent waited between 3 and 6 weeks, 13 percent waited between 6 weeks and 3 months, 12 percent waited between 4 and 6 months, 6 percent waited between 7 and 12 months, 2 percent waited between 13 and 18 months, and 2 percent waited more than 18 months for non-emergent obstetrical and gynaecological surgery between October 2004 and March 2005. For an extensive explanation and wait times for individual procedures, please refer to "Verification of current data with governments—Saskatchewan."

Table 5c: Ophthalmology (2005)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Cataract Removal	12.0 ¹	11.0 ²	33.0	11.0	20.0	12.0	12.0	12.0	29.0	11.0
Cornea Transplant	42.0 ¹	52.0	54.0	46.0	32.0	34.5	51.0	30.0	—	—
Cornea—Pterygium	8.0	8.8	18.0	5.0	12.0	12.0	11.0	8.0	15.0	8.0
Iris, Ciliary Body, Sclera, Anterior Chamber	8.0	6.0	12.0	11.0	12.0	9.0	8.0	6.0	1.0	7.0
Retina, Choroid, Vitreous	4.8	2.0	3.0	—	4.0	4.0	1.0	5.0	1.0	3.0
Lacrimal Duct	12.0	7.0	12.0	4.0	12.0	16.0	12.0	10.0	40.0	21.5
Strabismus	12.0	8.0	8.0	—	19.0	16.0	12.0	9.0	17.0	11.0
Operations on Eyelids	8.0	8.0	24.0	4.0	8.0	10.0	5.0	5.3	14.0	6.0
Glaucoma	8.0	6.0	8.0	4.0	10.0	6.0	6.0	5.0	11.0	4.0
Weighted Median	10.8 ¹	8.4 ²	27.6 ³	10.7	16.1	11.8	11.2	10.1	27.0	9.7

Note: Weighted median does not include treatment for glaucoma.

¹BC Ministry of Health web site reports median wait times of 7.0 weeks for eye surgery (ophthalmology), 7.9 weeks for cataract surgery, and 14.7 weeks for corneal transplant for the three months ending May 31, 2005. For an extensive explanation, please refer to "Verification of current data with governments—British Columbia."

²Alberta Health and Wellness reports median waits of 10 weeks for non-urgent eye surgery and 12 weeks for non-urgent cataract surgery for patients served in the 90 days preceding April 30, 2005.

³Saskatchewan Surgical Care Network web site reports that 4 percent of patients in Saskatchewan waited less than 24 hours, 10 percent waited between 24 hours and 3 weeks, 7 percent waited between 3 and 6 weeks, 16 percent waited between 6 weeks and 3 months, 23 percent waited between 4 and 6 months, 26 percent waited between 7 and 12 months, 11 percent waited between 13 and 18 months, and 2 percent waited more than 18 months for non-emergent eye surgery between October 2004 and March 2005. For an extensive explanation and wait times for individual procedures, please refer to "Verification of current data with governments—Saskatchewan."

Table 5d: Otolaryngology (2005)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Myringotomy	8.0	4.0	5.0	6.0	6.5	4.0	12.0	3.5	—	2.0
Tympanoplasty	12.0	8.0	82.5	9.0	8.0	8.0	18.0	11.0	—	2.5
Thyroid, Parathyroid, and Other Endocrine Glands	7.5	9.0	9.0	12.0	8.0	7.5	6.0	8.0	—	2.0
Tonsillectomy and/or Adenoidectomy	12.0	11.0	83.5	11.0	8.0	6.0	12.0	11.0	—	10.0
Rhinoplasty and/or Septal Surgery	12.0	8.5	83.5	9.0	9.0	8.0	18.0	10.0	—	4.0
Operations on Nasal Sinuses	12.0	10.0	67.5	9.0	8.0	8.0	18.0	11.0	—	2.5
Weighted Median	10.7 ¹	8.3 ²	45.1 ³	8.9	7.6	5.6	13.0	7.8	—	4.7

¹BC Ministry of Health web site reports a 5.4 week median wait time for ear, nose, and throat surgery for the three months ending May 31, 2005. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness reports a 7 week median wait for non-urgent ear, nose, and throat surgery for patients served in the 90 days preceding April 30, 2005.

³Saskatchewan Surgical Care Network web site reports that 6 percent of patients in Saskatchewan waited less than 24 hours, 33 percent waited between 24 hours and 3 weeks, 17 percent waited between 3 and 6 weeks, 9 percent waited between 6 weeks and 3 months, 5 percent waited between 4 and 6 months, 5 percent waited between 7 and 12 months, 6 percent waited between 13 and 18 months, and 18 percent waited more than 18 months for non-emergent ear, nose, and throat surgery between October 2004 and March 2005. For an extensive explanation and wait times for individual procedures, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5e: General Surgery (2005)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Hernia/Hydrocele	12.0	5.0	14.0	5.0	6.0	8.0	8.0	10.0	8.0	26.0
Cholecystectomy	11.5 ¹	6.0 ²	14.0	4.5	5.0	8.0	6.0	8.0	3.0	14.5
Colonoscopy	9.0	8.0	9.0	5.0	8.0	6.0	8.0	12.0	5.0	22.0
Intestinal Operations	4.0	4.0	4.3	2.0	4.0	4.0	4.0	6.0	3.5	3.0
Haemorrhoidectomy	12.0	6.0	20.0	6.0	6.0	12.0	9.0	10.0	4.0	10.0
Breast Biopsy	2.5	2.0	3.0	2.0	3.0	2.0	2.0	3.0	2.0	2.0
Mastectomy	2.5	2.0	3.0	2.3	3.0	2.8	2.0	2.5	2.0	1.5
Bronchus and Lung	4.3	—	—	2.0	4.5	2.5	3.0	2.5	—	—
Aneurysm Surgery	5.5	3.0	1.0	1.0	8.0	16.0	—	—	—	3.0
Varicose Veins	15.0	12.0	35.0	4.5	7.0	12.0	8.0	9.5	4.0	27.0
Weighted Median	7.6 ¹	5.4 ²	9.7 ³	3.7	5.7	5.9	5.3	8.0	4.3	14.4

¹BC Ministry of Health web site reports median wait times of 3.1 weeks for general surgery and 5.0 weeks for gall bladder surgery for the three months ending May 31, 2005. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness reports median waits of 5 weeks for non-urgent general surgery and 5 weeks for non-urgent gall bladder removal surgery (cholecystectomy) for patients served in the 90 days preceding April 30, 2005.

³Saskatchewan Surgical Care Network web site reports that 30 percent of patients in Saskatchewan waited less than 24 hours, 31 percent waited between 24 hours and 3 weeks, 15 percent waited between 3 and 6 weeks, 11 percent waited between 6 weeks and 3 months, 5 percent waited between 4 and 6 months, 3 percent waited between 7 and 12 months, 1 percent waited between 13 and 18 months, and 2 percent waited more than 18 months for non-emergent general surgery between October 2004 and March 2005. For an extensive explanation and wait times for individual procedures, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5f: Neurosurgery (2005)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Peripheral Nerve	10.0	6.0	6.0	6.5	12.0	5.5	18.0	4.0	—	5.8
Disc Surgery/Laminectomy	13.0	12.0	14.0	5.0	10.0	11.0	36.0	12.0	—	6.3
Elective Cranial Bone Flap	6.5	3.0	6.0	3.0	6.0	3.3	6.0	12.0	—	3.8
Aneurysm Surgery	8.0	8.0	10.0	2.8	6.0	4.0	8.0	20.0	—	0.8
Carotid endarterectomy	7.5	2.0	1.5	1.8	4.0	4.0	4.0	2.0	—	—
Weighted Median	9.1 ¹	5.8 ²	8.5 ³	4.2	8.2	6.9	17.8	10.4	—	5.1

¹BC Ministry of Health web site reports a 3.9 week median wait time for neurosurgery for the three months ending May 31, 2005. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness reports a 4 week median wait for non-urgent neurosurgery for patients served in the 90 days preceding April 30, 2005.

³Saskatchewan Surgical Care Network web site reports that 38 percent of patients in Saskatchewan waited less than 24 hours, 25 percent waited between 24 hours and 3 weeks, 10 percent waited between 3 and 6 weeks, 7 percent waited between 6 weeks and 3 months, 10 percent waited between 4 and 6 months, 4 percent waited between 7 and 12 months, 2 percent waited between 13 and 18 months, and 5 percent waited more than 18 months for non-emergent neurosurgery between October 2004 and March 2005. For an extensive explanation and wait times for individual procedures, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5g: Orthopaedic Surgery (2005)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Meniscectomy/Arthroscopy	16.0	11.5	21.0	16.0	12.0	16.0	10.0	26.0	12.0	10.0
Removal of Pins	16.0	15.0	18.0	16.0	12.0	20.0	18.0	25.0	12.0	7.0
Arthroplasty (Hip, Knee, Ankle, Shoulder)	54.0 ¹	40.0 ²	42.0	52.0	30.0	24.0	30.0	40.0	35.0	16.0
Arthroplasty (Interphalangeal, Metatarsophalangeal)	20.0	24.0	42.0	8.0	16.0	16.0	12.0	40.0	35.0	12.0
Hallux Valgus/Hammer Toe	17.0	14.0	42.0	20.0	12.0	20.0	12.0	25.0	16.0	8.0
Digit Neuroma	13.0	13.0	42.0	17.5	14.0	16.0	18.0	21.5	12.0	8.0
Rotator Cuff Repair	18.0	16.0	30.0	20.0	16.0	16.0	12.0	19.0	14.0	8.0
Ostectomy (All Types)	20.0	12.0	42.0	8.5	12.0	20.0	11.0	35.0	35.0	12.0
Routine Spinal Instability	32.0	16.0	42.0	20.0	19.5	20.0	52.0	104.0	50.0	12.0
Weighted Median	33.9 ¹	26.7 ²	37.1 ³	33.0	21.9	20.3	22.0	35.2	26.5	11.7

¹BC Ministry of Health web site reports median wait times of 8.1 weeks for orthopaedic surgery, 22.9 weeks for hip replacement, and 26.0 weeks for knee replacement for the three months ending May 31, 2005. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness reports median waits of 12 weeks for non-urgent orthopaedic surgery, 20 weeks for non-urgent hip replacement, and 25 weeks for non-urgent knee replacement for patients served in the 90 days preceding April 30, 2005.

³Saskatchewan Surgical Care Network web site reports that 35 percent of patients in Saskatchewan waited less than 24 hours, 7 percent waited between 24 hours and 3 weeks, 6 percent waited between 3 and 6 weeks, 10 percent waited between 6 weeks and 3 months, 15 percent waited between 4 and 6 months, 11 percent waited between 7 and 12 months, 5 percent waited between 13 and 18 months, and 10 percent waited more than 18 months for non-emergent orthopaedic surgery between October 2004 and March 2005. For an extensive explanation and wait times for individual procedures, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5h: Cardiovascular Surgery (2005)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

		BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Emergent	Coronary Artery Bypass	0.3	0.0	0.5	0.0	0.0	0.0	0.0	—	—	0.5
	Valves & Septa of the Heart	0.3	0.0	0.5	0.0	0.0	0.0	0.0	—	—	0.5
	Aneurysm Surgery	0.0	0.5	0.3	0.3	0.0	0.0	0.0	0.0	0.2	0.1
	Carotid Endarterectomy	0.3	0.5	0.2	0.5	0.0	0.0	1.0	0.0	0.2	0.1
	Pacemaker Operations	0.0	0.0	0.5	0.5	0.3	0.0	0.3	1.0	0.2	—
	Weighted Median	0.1	0.0	0.5	0.2 ⁴	0.1	0.0	0.2	0.9	0.2	0.5
Urgent	Coronary Artery Bypass	2.0	2.0	2.0	1.5	1.0	1.0	0.5	—	—	1.0
	Valves & Septa of the Heart	2.0	2.0	2.0	1.5	1.0	1.0	0.5	—	—	1.0
	Aneurysm Surgery	2.0	2.0	1.5	1.5	1.8	0.5	2.0	2.0	2.0	1.5
	Carotid Endarterectomy	1.8	3.0	5.5	1.8	1.8	1.0	3.5	2.0	6.0	1.5
	Pacemaker Operations	1.0	1.0	0.5	1.5	1.0	0.4	2.0	2.0	6.0	—
	Weighted Median	1.5	1.6	1.5 ³	1.5 ⁴	1.0	0.8	1.3	2.0	6.0	1.0
Elective	Coronary Artery Bypass	8.0	6.0 ²	4.0	3.5	3.0 ⁵	4.0	8.0	—	—	54.0
	Valves & Septa of the Heart	9.0	7.0	4.0	3.5	3.0	4.0	8.0	—	—	54.0
	Aneurysm Surgery	6.0	10.0	11.0	3.0	4.5	5.0	8.0	10.0	6.0	8.5
	Carotid Endarterectomy	10.0	10.0	4.0	3.5	5.8	7.0	10.0	8.0	—	7.3
	Pacemaker Operations	9.0	5.0	3.0	4.5	4.0	3.0	6.0	4.0	12.0	—
	Weighted Median	8.8 ¹	5.9 ²	3.6 ³	4.0 ⁴	3.5	3.8	7.2	4.2	12.0	51.5

¹BC Ministry of Health web site reports median wait times of 8.0 weeks for cardiac surgery and 2.1 weeks for vascular surgery for the three months ending May 31, 2005. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness reports median waits of 2 weeks for non-urgent cardiac surgery, 3 weeks for non-urgent thoracic surgery, 3 weeks for non-urgent vascular surgery, and 1 week for non-urgent coronary artery bypass surgery for patients served in the 90 days preceding April 30, 2005.

³Saskatchewan Surgical Care Network web site reports that 43 percent of patients in Saskatchewan waited less than 24 hours, 38 percent waited between 24 hours and 3 weeks, 7 percent waited between 3 and 6 weeks, 6 percent waited between 6 weeks and 3 months, 3 percent waited between 4 and 6 months, 1 percent waited between 7 and 12 months, 1 percent waited between 13 and 18 months, and 1 percent waited more than 18 months for non-emergent cardiovascular surgery between October 2004 and March 2005. For an extensive explanation and wait times for individual procedures, please refer to “Verification of current data with governments—Saskatchewan.”

⁴Manitoba Health web site reports a median waiting time of 14.5 days (2.1 weeks) for all cardiac surgery cases performed in Winnipeg for the quarter ending June 2005.

⁵Cardiac Care Network of Ontario reports a median wait time for bypass surgery of 20 days (2.9 weeks) for the three months ending April 30, 2005.

Table 5i: Urology (2005)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Non-radical Prostatectomy	10.0	6.0	79.0	3.3	6.0	8.0	6.5	8.0	—	20.0
Radical Prostatectomy	5.0	7.0	7.3	3.5	6.0	6.0	4.5	8.0	—	6.0
Transurethral Resection—Bladder	4.0	3.5	5.3	1.8	4.0	4.0	5.0	3.5	—	6.0
Radical Cystectomy	4.0	4.0	7.3	3.5	6.0	4.0	4.0	4.0	—	4.0
Cystoscopy	6.0	2.5	3.5	1.8	3.0	6.0	7.0	8.0	—	8.0
Hernia/Hydrocele	15.5	8.0	79.0	7.5	6.0	12.0	12.0	8.0	—	9.0
Bladder Fulguration	6.5	4.0	3.8	2.0	4.0	4.0	5.0	4.0	—	7.0
Ureteral Reimplantation for Reflux	15.0	12.0	22.0	4.0	8.0	4.0	11.0	10.0	—	24.0
Weighted Median	7.2 ¹	3.4 ²	13.2 ³	2.6	3.6	6.1	7.3	7.4	—	8.3

¹BC Ministry of Health web site reports a 4.1 week median wait time for urology for the three months ending May 31, 2005. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness reports a 5 week median wait for non-urgent urological surgery for patients served in the 90 days preceding April 30, 2005.

³Saskatchewan Surgical Care Network web site reports that 20 percent of patients in Saskatchewan waited less than 24 hours, 26 percent waited between 24 hours and 3 weeks, 16 percent waited between 3 and 6 weeks, 14 percent waited between 6 weeks and 3 months, 10 percent waited between 4 and 6 months, 4 percent waited between 7 and 12 months, 2 percent waited between 13 and 18 months, and 8 percent waited more than 18 months for non-emergent urological surgery between October 2004 and March 2005. For an extensive explanation and wait times for individual procedures, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5j: Internal Medicine (2005)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Colonoscopy	7.0	10.0	8.0	4.0	7.0	7.5	5.5	4.5	5.5	4.0
Angiography /Angioplasty	6.5	4.8	7.5	6.0	4.0	4.0	20.0	4.5	9.0	4.0
Bronchoscopy	3.0	4.0	2.0	2.0	3.0	2.0	2.5	2.5	5.5	2.0
Gastroscopy	6.0	8.0	5.8	3.5	5.0	4.0	2.8	3.0	5.5	4.0
Weighted Median	6.6	8.6	7.6	4.1	6.1	6.1	14.0	4.2	5.8	3.9

Table 5k: Radiation Oncology (2005)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Cancer of the Larynx	—	3.5	2.0	3.0	2.0	2.0	2.0	2.5	3.0	2.0
Cancer of the Cervix	—	4.0	3.0	3.0	2.0	2.5	2.0	1.8	2.5	2.0
Lung Cancer	—	3.0	6.0	4.0	2.3	3.0	2.0	3.0	2.5	2.0
Prostate Cancer	—	9.0 ²	7.0	4.0	4.0	7.0	3.5	3.3	8.0	4.0
Breast Cancer	—	6.5 ²	6.0	3.3	2.8	5.0	4.0	3.0	8.0	3.0
Early Side Effects from Treatment	—	2.0	0.5	0.0	0.5	0.5	0.5	0.5	0.0	0.2
Late Side Effects from Treatment	—	2.5	2.0	0.0	1.5	0.5	2.0	1.0	1.0	2.0
Weighted Median	— ¹	6.5	6.3	3.7 ³	3.0	4.5 ⁴	3.1	3.0	6.1	3.0

Note: Weighted median does not include early or late side effects from treatment.

¹BC Ministry of Health web site reports a 0.7 week median wait time for radiotherapy for the three months ending May 31, 2005. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness web site reports wait times ranging from less than 3 weeks to 4 weeks for radiation therapy for breast cancer, and wait times ranking from less than 3 weeks to 4 weeks for radiation therapy for prostate cancer at July 31, 2005.

³Manitoba Health web site reports a 1.1 week median wait time for radiotherapy for the quarter ending June 30, 2005.

⁴Quebec Ministry of Health and Social Services web site reports wait times ranging from 0 to 8 weeks (depending on the type of cancer) for radiation oncology.

Table 5l: Medical Oncology (2005)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Cancer of the Larynx	1.0	2.3	—	—	3.0	2.3	2.5	2.0	—	1.5
Cancer of the Cervix	1.3	2.5	—	—	2.5	2.0	2.0	2.0	—	3.0
Lung Cancer	1.0	3.0	—	—	3.0	2.0	2.5	2.0	2.0	3.0
Breast Cancer	1.0	4.0 ¹	—	—	3.0	1.5	2.5	5.0	2.0	6.0
Side Effects from Treatment	0.5	0.5	—	—	0.5	0.0	0.5	0.5	0.1	0.5
Weighted Median	1.0	3.5	—	—	3.0	1.8	2.5	3.3	2.0	4.5

Note: Weighted median does not include side effects from treatment.

¹Alberta Health and Wellness web site reports a wait time of 1 week for chemotherapy for breast cancer at July 31, 2005.

Table 6: Comparison of Median Weeks Waited to Receive Treatment after Appointment with Specialist, by Selected Specialties, 2004 and 2005

	British Columbia			Alberta			Saskatchewan			Manitoba			Ontario		
	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg
Plastic Surgery	24.2	22.8	6%	21.0	18.2	15%	48.1	59.7	-19%	30.4	23.7	28%	16.1	14.4	12%
Gynaecology	8.0	8.6	-7%	6.9	7.1	-3%	15.1	13.6	11%	7.2	7.3	-1%	6.0	6.1	0%
Ophthalmology	10.8	12.0	-10%	8.4	8.1	4%	27.6	30.5	-10%	10.7	9.8	10%	16.1	17.1	-6%
Otolaryngology	10.7	16.7	-36%	8.3	7.5	11%	45.1	55.8	-19%	8.9	5.8	52%	7.6	10.0	-24%
General Surgery	7.6	7.6	0%	5.4	4.9	11%	9.7	13.4	-27%	3.7	4.5	-17%	5.7	4.7	22%
Neurosurgery	9.1	8.3	10%	5.8	6.3	-8%	8.5	12.5	-32%	4.2	2.5	68%	8.2	8.8	-7%
Orthopaedic Surgery	33.9	32.2	5%	26.7	24.1	11%	37.1	75.2	-51%	33.0	18.4	79%	21.9	18.0	22%
Cardiovascular Surgery (Urgent)	1.5	1.9	-22%	1.6	3.1	-47%	1.5	2.0	-23%	1.5	1.0	47%	1.0	1.0	1%
Cardiovascular Surgery (Elective)	8.8	13.3	-34%	5.9	8.0	-26%	3.6	12.4	-71%	4.0	8.6	-54%	3.5	4.2	-17%
Urology	7.2	6.9	4%	3.4	3.4	-2%	13.2	13.3	-1%	2.6	6.4	-60%	3.6	3.6	2%
Internal Medicine	6.6	6.3	5%	8.6	10.5	-19%	7.6	6.5	17%	4.1	3.1	31%	6.1	5.4	12%
Radiation Oncology	—	1.5	—	6.5	5.0	29%	6.3	3.1	102%	3.7	2.8	34%	3.0	6.0	-51%
Medical Oncology	1.0	1.5	-33%	3.5	4.2	-17%	—	—	—	—	—	—	3.0	2.5	20%
Weighted Median	11.2	11.6	-4%	8.6	8.3	4%	18.3	24.5	-25%	9.6	7.8	22%	8.7	8.2	5%

Note: Percentage changes are calculated from exact weighted medians. The exact weighted medians have been rounded to one decimal place for inclusion in the table.

Table 6: Comparison of Median Weeks Waited to Receive Treatment after Appointment with Specialist, by Selected Specialties, 2004 and 2005

	Quebec			New Brunswick			Nova Scotia			Prince Edward Island			Newfoundland		
	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg
Plastic Surgery	14.2	16.0	-11%	28.0	22.8	22%	61.3	34.5	77%	25.8	22.3	16%	18.1	45.2	-60%
Gynaecology	6.3	6.1	4%	13.4	6.0	124%	8.5	6.7	26%	4.5	9.6	-53%	4.1	4.5	-9%
Ophthalmology	11.8	15.3	-23%	11.2	10.7	5%	10.1	9.7	4%	27.0	20.2	33%	9.7	7.5	29%
Otolaryngology	5.6	5.8	-4%	13.0	8.3	58%	7.8	6.8	16%	—	—	—	4.7	6.2	-24%
General Surgery	5.9	5.4	9%	5.3	4.7	15%	8.0	4.2	91%	4.3	11.9	-64%	14.4	4.9	191%
Neurosurgery	6.9	6.7	2%	17.8	25.1	-29%	10.4	5.1	104%	—	—	—	5.1	4.1	23%
Orthopaedic Surgery	20.3	20.8	-3%	22.0	20.9	6%	35.2	30.9	14%	26.5	41.0	-35%	11.7	16.9	-31%
Cardiovascular Surgery (Urgent)	0.8	0.8	-2%	1.3	3.1	-57%	2.0	2.2	-10%	6.0	—	—	1.0	1.4	-29%
Cardiovascular Surgery (Elective)	3.8	4.1	-8%	7.2	8.5	-15%	4.2	7.8	-46%	12.0	—	—	51.5	58.6	-12%
Urology	6.1	6.5	-7%	7.3	21.6	-66%	7.4	5.8	29%	—	3.0	—	8.3	9.1	-9%
Internal Medicine	6.1	5.4	12%	14.0	8.2	71%	4.2	5.7	-25%	5.8	15.8	-63%	3.9	7.6	-49%
Radiation Oncology	4.5	8.5	-48%	3.1	10.6	-71%	3.0	2.9	6%	6.1	8.1	-25%	3.0	6.2	-52%
Medical Oncology	1.8	1.3	40%	2.5	1.5	66%	3.3	1.5	122%	2.0	2.6	-23%	4.5	6.2	-28%
Weighted Median	8.4	9.2	-9%	11.6	10.9	6%	11.1	8.9	24%	10.7	15.7	-32%	9.4	8.9	5%

Note: Percentage changes are calculated from exact weighted medians. The exact weighted medians have been rounded to one decimal place for inclusion in the table.

Table 7: Frequency Distribution of Waiting Times (Specialist to Treatment) by Province 2005—Proportion of Survey Waiting Times that Fall Within Given Ranges

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
0 - 3.99 Weeks	18.6%	22.5%	18.5%	29.7%	23.1%	25.3%	20.1%	20.8%	36.5%	32.7%
4 - 7.99 Weeks	21.9%	27.1%	15.6%	31.7%	29.2%	26.0%	20.5%	24.2%	20.0%	24.5%
8 - 12.99 Weeks	25.8%	27.1%	17.2%	17.0%	24.2%	22.6%	28.5%	24.9%	25.9%	20.8%
13 - 25.99 Weeks	17.7%	13.6%	15.4%	11.5%	12.8%	14.8%	15.7%	12.0%	9.4%	11.5%
26 - 51.99 Weeks	8.7%	5.8%	14.1%	6.2%	6.8%	7.0%	8.1%	10.6%	7.1%	6.3%
1 year plus	7.4%	3.9%	19.2%	4.0%	3.9%	4.3%	7.1%	7.7%	1.2%	4.1%

Note: Columns do not necessarily sum to 100 due to rounding.

Table 8: Median Reasonable Patient Wait for Treatment after Appointment with Specialist 2005 (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	Can
Plastic Surgery	9.9	9.7	19.6	8.2	8.7	9.2	14.1	21.6	12.0	7.4	10.0
Gynaecology	5.6	5.6	10.6	5.5	4.8	5.1	7.6	6.6	9.3	3.7	5.4
Ophthalmology	7.4	6.6	10.7	10.2	6.8	7.9	8.9	10.3	14.9	8.6	7.7
Otolaryngology	5.6	6.3	16.0	8.8	5.2	4.5	7.8	8.9	—	4.3	5.9
General Surgery	3.9	3.8	7.9	3.4	3.6	4.2	4.3	3.8	3.1	4.6	4.0
Neurosurgery	3.4	3.7	6.6	6.4	5.0	2.8	7.7	6.9	—	—	4.3
Orthopaedic Surgery	9.3	9.0	9.9	12.5	9.9	9.9	9.4	16.8	9.7	7.8	10.0
Cardiovascular Surgery (Urgent)	0.7	1.1	1.4	1.5	0.5	0.5	1.3	1.5	2.0	1.0	0.7
Cardiovascular Surgery (Elective)	5.4	6.0	5.8	5.0	3.4	3.5	6.9	4.4	3.0	5.1	4.2
Urology	3.0	2.4	4.5	3.0	2.5	3.9	6.3	7.1	—	4.3	3.3
Internal Medicine	2.6	3.6	3.1	2.9	2.7	3.4	5.1	4.0	3.2	3.2	3.1
Radiation Oncology	—	3.5	5.3	4.1	2.9	3.7	5.7	3.3	3.1	3.3	3.7
Medical Oncology	2.0	2.6	—	—	3.0	2.0	2.5	2.9	4.0	4.2	2.6
Weighted Median	5.1	4.9	8.0	5.9	4.6	5.5	7.0	7.4	6.3	4.8	5.2

Table 9a: Plastic Surgery (2005)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Mammoplasty	12.0	12.0	18.0	12.0	12.0	12.0	13.0	37.0	12.0	15.0
Neurolysis	7.5	6.0	10.0	6.0	6.0	5.0	9.8	6.0	12.0	4.0
Blepharoplasty	8.0	10.0	8.0	8.0	8.0	8.0	17.0	16.0	12.0	12.0
Rhinoplasty	8.0	11.0	30.0	6.0	7.0	11.0	18.5	27.0	12.0	12.0
Scar Revision	10.0	10.0	18.0	8.0	10.0	12.0	24.5	27.0	12.0	8.0
Hand Surgery	8.0	8.0	16.5	6.0	6.0	8.0	9.5	7.0	12.0	4.0
Craniofacial Procedures	12.0	5.0	—	2.0	6.0	8.0	16.5	11.0	12.0	8.0
Skin Cancer and other Tumors	4.0	2.5	4.0	4.0	4.0	3.8	3.5	2.8	12.0	4.0
Weighted Median	9.9	9.7	19.6	8.2	8.7	9.2	14.1	21.6	12.0	7.4

Note: Weighted median does not include craniofacial procedures or skin cancer and other tumors.

Table 9b: Gynaecology (2005)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Dilation & Curettage	3.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	3.0	2.0
Tubal Ligation	6.0	7.5	14.0	6.0	6.0	8.0	9.0	8.0	12.0	4.0
Hysterectomy (Vaginal/Abdominal)	8.0	7.0	12.0	6.0	5.0	6.0	8.0	8.0	12.0	5.0
Vaginal Repair	8.0	7.0	18.0	6.0	6.0	8.0	11.0	8.0	12.0	5.0
Tuboplasty	6.5	7.5	25.0	9.0	6.0	10.0	8.0	8.0	12.0	10.0
Laparoscopic Procedures	5.0	6.0	11.0	5.0	5.0	4.0	9.0	6.0	8.0	5.0
Hysteroscopic Procedures	4.0	5.0	11.0	4.0	4.0	4.0	5.5	6.0	8.0	4.0
Weighted Median	5.6	5.6	10.6	5.5	4.8	5.1	7.6	6.6	9.3	3.7

Table 9c: Ophthalmology (2005)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Cataract Removal	8.0	8.0	12.0	11.0	8.0	8.0	9.0	12.0	16.0	9.5
Cornea Transplant	12.0	7.0	12.0	11.5	8.0	16.0	12.0	34.0	—	—
Cornea—Pterygium	9.0	8.5	12.0	4.0	8.0	12.0	8.0	12.0	12.0	9.0
Iris, Ciliary Body, Sclera, Anterior Chamber	10.0	6.0	6.0	11.0	5.0	4.0	10.0	6.0	1.0	10.5
Retina, Choroid, Vitreous	3.5	3.5	3.0	—	3.0	4.0	—	4.0	1.0	2.0
Lacrimal Duct	8.0	9.0	12.0	4.0	6.0	15.0	8.0	12.0	12.0	6.5
Strabismus	8.0	6.0	12.0	—	6.5	9.0	8.0	12.0	9.0	7.0
Operations on Eyelids	8.0	7.0	12.0	4.0	6.0	10.0	6.0	12.0	8.5	10.5
Glaucoma	4.0	4.0	3.0	2.0	4.0	4.0	5.0	9.0	7.0	6.0
Weighted Median	7.4	6.6	10.7	10.2	6.8	7.9	8.9	10.3	14.9	8.6

Note: Weighted median does not include treatment for glaucoma.

Table 9d: Otolaryngology (2005)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Myringotomy	4.0	4.0	6.0	8.0	4.0	4.0	8.0	6.0	—	3.0
Tympanoplasty	8.0	8.0	26.0	9.0	6.0	6.0	8.0	12.0	—	4.0
Thyroid, Parathyroid, and Other Endocrine Glands	4.0	4.0	8.0	12.0	4.0	4.0	4.0	12.0	—	—
Tonsillectomy and/or Adenoidectomy	6.0	8.0	26.0	9.0	6.0	5.0	8.0	9.0	—	6.0
Rhinoplasty and/or Septal Surgery	7.0	8.0	26.0	10.0	6.0	8.0	8.0	12.0	—	4.0
Operations on Nasal Sinuses	6.0	8.0	19.0	7.0	6.0	4.0	8.0	12.0	—	4.0
Weighted Median	5.6	6.3	16.0	8.8	5.2	4.5	7.8	8.9	—	4.3

Table 9e: General Surgery (2005)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Hernia/Hydrocele	5.5	5.5	16.0	5.0	4.0	6.0	6.0	5.5	4.0	8.0
Cholecystectomy	4.0	4.0	12.0	4.0	4.0	4.0	4.0	4.0	4.0	6.5
Colonoscopy	4.0	4.0	4.0	4.0	4.0	4.0	4.5	4.0	2.8	5.0
Intestinal Operations	3.0	3.0	4.5	2.5	3.0	3.8	4.0	3.0	3.0	2.5
Haemorrhoidectomy	8.0	5.5	14.0	4.0	6.0	8.0	8.0	5.0	4.0	6.0
Breast Biopsy	2.0	2.0	3.0	2.0	2.0	2.0	2.0	2.3	2.0	1.8
Mastectomy	2.0	2.0	2.0	2.0	2.0	2.3	2.0	2.0	2.0	1.8
Bronchus and Lung	2.0	2.0	—	1.0	2.0	3.5	2.0	2.5	—	—
Aneurysm Surgery	2.5	3.0	1.0	1.0	3.5	6.0	—	—	—	1.0
Varicose Veins	10.0	8.0	17.5	5.0	8.0	12.0	12.0	9.5	4.0	4.0
Weighted Median	3.9	3.8	7.9	3.4	3.6	4.2	4.3	3.8	3.1	4.6

Table 9f: Neurosurgery (2005)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Peripheral Nerve	4.0	4.0	5.0	10.0	7.0	4.0	8.0	8.0	—	—
Disc Surgery/ Laminectomy	4.0	6.0	7.0	10.0	6.0	3.0	13.5	4.0	—	—
Elective Cranial Bone Flap	3.0	2.5	7.0	3.0	3.8	2.3	4.0	8.0	—	—
Aneurysm Surgery	3.3	5.0	6.0	8.0	5.0	4.0	4.0	6.0	—	—
Carotid endarterectomy	2.0	2.0	0.5	1.5	2.0	1.5	2.0	2.0	—	—
Weighted Median	3.4	3.7	6.6	6.4	5.0	2.8	7.7	6.9	—	—

Table 9g: Orthopaedic Surgery (2005)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Meniscectomy/Arthroscopy	6.0	5.0	6.0	7.0	6.0	6.0	6.0	8.0	6.0	5.0
Removal of Pins	7.5	8.0	8.0	6.0	8.0	12.0	12.0	14.0	6.0	6.0
Arthroplasty (Hip, Knee, Ankle, Shoulder)	12.0	12.0	12.0	16.0	12.0	11.0	10.0	18.0	12.0	11.0
Arthroplasty (Interphalangeal, Metatarsophalangeal)	8.0	6.0	12.0	7.5	8.0	12.0	10.0	24.0	12.0	7.5
Hallux Valgus/Hammer Toe	8.0	6.0	12.0	13.0	10.0	12.0	8.0	24.0	6.0	6.0
Digit Neuroma	7.0	6.0	6.0	12.0	8.0	8.0	12.0	20.0	6.0	6.0
Rotator Cuff Repair	6.0	6.0	6.0	8.0	6.0	6.0	6.3	12.0	6.0	6.0
Ostectomy (All Types)	8.0	6.0	9.0	8.0	8.0	12.0	9.0	20.0	12.0	6.0
Routine Spinal Instability	8.0	6.0	12.0	12.0	12.0	12.0	12.0	25.0	25.0	8.0
Weighted Median	9.3	9.0	9.9	12.5	9.9	9.9	9.4	16.8	9.7	7.8

Table 9h: Cardiovascular Surgery (2005)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	
Emergent	Coronary Artery Bypass	0.0	0.0	0.5	0.0	0.0	0.0	0.5	—	0.5	
	Valves & Septa of the Heart	0.0	0.0	0.5	0.0	0.0	0.0	0.5	—	0.5	
	Aneurysm Surgery	0.0	0.5	0.3	0.0	0.0	0.0	0.0	0.2	0.3	
	Carotid Endarterectomy	0.0	0.5	0.2	—	0.0	0.0	0.8	0.0	0.2	0.3
	Pacemaker Operations	0.0	0.0	0.5	0.5	0.0	0.0	0.5	0.3	0.2	—
	Weighted Median	0.0	0.0	0.5	0.2	0.0	0.0	0.3	0.4	0.2	0.5
Urgent	Coronary Artery Bypass	0.5	1.3	2.0	1.5	0.5	0.8	0.5	2.0	—	1.0
	Valves & Septa of the Heart	0.5	1.5	2.0	1.5	0.4	0.8	0.5	2.0	—	1.0
	Aneurysm Surgery	1.0	2.0	1.0	1.5	0.6	0.3	1.0	1.0	1.0	0.3
	Carotid Endarterectomy	2.0	2.0	1.8	—	0.4	0.0	2.0	1.0	2.0	0.3
	Pacemaker Operations	0.8	0.8	0.5	1.5	0.5	0.2	2.0	0.8	2.0	—
	Weighted Median	0.7	1.1	1.4	1.5	0.5	0.5	1.3	1.5	2.0	1.0
Elective	Coronary Artery Bypass	6.0	6.5	8.0	5.0	4.0	3.8	8.0	7.0	—	5.0
	Valves & Septa of the Heart	6.0	8.0	8.0	5.0	4.0	4.0	8.0	7.0	—	6.0
	Aneurysm Surgery	4.0	5.5	9.0	5.0	4.0	4.0	6.0	3.0	3.0	4.5
	Carotid Endarterectomy	5.0	4.0	5.0	—	4.0	4.0	5.0	2.5	—	3.3
	Pacemaker Operations	5.0	5.0	3.0	5.0	2.5	3.0	6.0	1.0	—	—
	Weighted Median	5.4	6.0	5.8	5.0	3.4	3.5	6.9	4.4	3.0	5.1

Table 9i: Urology (2005)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Non-radical Prostatectomy	4.5	3.5	15.5	3.5	4.0	6.0	5.0	4.0	—	5.5
Radical Prostatectomy	4.0	4.0	3.0	3.0	4.0	4.0	3.5	4.0	—	6.0
Transurethral Resection—Bladder	2.0	2.0	2.5	2.0	2.0	3.0	3.0	2.0	—	3.0
Radical Cystectomy	2.0	3.0	3.0	2.5	3.0	3.0	3.5	2.0	—	2.0
Cystoscopy	2.0	2.0	2.5	2.0	2.0	3.5	6.0	8.0	—	4.0
Hernia/Hydrocele	8.0	5.5	19.0	10.0	6.0	12.0	12.0	10.0	—	10.0
Bladder Fulguration	3.0	2.5	3.0	2.0	2.3	3.0	4.0	3.0	—	2.5
Ureteral Reimplantation for Reflux	6.5	4.5	12.0	12.0	5.0	8.0	6.0	10.0	—	24.0
Weighted Median	3.0	2.4	4.5	3.0	2.5	3.9	6.3	7.1	—	4.3

Table 9j: Internal Medicine (2005)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Colonoscopy	3.0	4.0	3.0	3.0	3.0	4.0	4.0	4.0	3.0	3.5
Angiography/ Angioplasty	2.0	2.5	3.5	2.0	2.0	2.5	6.0	4.0	6.0	2.0
Bronchoscopy	2.0	2.5	1.5	2.0	2.0	2.0	3.0	3.5	3.0	3.0
Gastroscopy	2.0	4.0	3.0	3.5	2.5	2.0	3.0	4.0	3.0	3.5
Weighted Median	2.6	3.6	3.1	2.9	2.7	3.4	5.1	4.0	3.2	3.2

Table 9k: Radiation Oncology (2005)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Cancer of the Larynx	—	4.0	2.0	2.5	2.0	2.0	2.0	2.0	1.0	2.0
Cancer of the Cervix	—	4.0	2.0	3.0	2.0	2.0	2.0	1.3	1.0	2.0
Lung Cancer	—	2.0	2.0	4.0	2.0	2.0	2.0	3.0	1.5	2.0
Prostate Cancer	—	4.0	6.0	5.5	4.0	7.0	4.0	4.0	4.0	4.0
Breast Cancer	—	4.0	8.0	3.0	2.8	4.0	12.0	3.0	4.0	4.0
Early Side Effects from Treatment	—	1.5	0.5	0.0	1.0	0.5	0.5	0.5	0.0	0.2
Late Side Effects from Treatment	—	3.0	1.5	0.0	2.0	0.5	3.0	1.0	1.0	2.0
Weighted Median	—	3.5	5.3	4.1	2.9	3.7	5.7	3.3	3.1	3.3

Note: Weighted median does not include early or late side effects from treatment.

Table 9l: Medical Oncology (2005)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Cancer of the Larynx	2.0	3.0	—	—	2.0	2.0	2.5	2.0	—	3.0
Cancer of the Cervix	2.0	2.5	—	—	2.0	2.0	2.0	2.0	—	4.0
Lung Cancer	2.0	2.5	—	—	2.0	2.0	2.5	2.0	4.0	2.0
Breast Cancer	2.0	2.8	—	—	4.0	2.0	2.5	4.0	4.0	6.0
Side Effects from Treatment	0.2	0.6	—	—	0.5	0.0	0.5	1.0	0.1	0.5
Weighted Median	2.0	2.6	—	—	3.0	2.0	2.5	2.9	4.0	4.2

Note: Weighted median does not include side effects from treatment.

Table 10: Comparison between the Median Actual Weeks Waited and the Median Reasonable Number of Weeks to Wait for Treatment after Appointment with Specialist, by Selected Specialties, 2005

	British Columbia			Alberta			Saskatchewan			Manitoba			Ontario		
	A	R	D	A	R	D	A	R	D	A	R	D	A	R	D
Plastic Surgery	24.2	9.9	145%	21.0	9.7	116%	48.1	19.6	145%	30.4	8.2	269%	16.1	8.7	85%
Gynaecology	8.0	5.6	45%	6.9	5.6	25%	15.1	10.6	42%	7.2	5.5	32%	6.0	4.8	25%
Ophthalmology	10.8	7.4	47%	8.4	6.6	27%	27.6	10.7	157%	10.7	10.2	5%	16.1	6.8	137%
Otolaryngology	10.7	5.6	90%	8.3	6.3	31%	45.1	16.0	182%	8.9	8.8	1%	7.6	5.2	47%
General Surgery	7.6	3.9	97%	5.4	3.8	41%	9.7	7.9	24%	3.7	3.4	8%	5.7	3.6	55%
Neurosurgery	9.1	3.4	171%	5.8	3.7	60%	8.5	6.6	28%	4.2	6.4	-34%	8.2	5.0	65%
Orthopaedic Surgery	33.9	9.3	265%	26.7	9.0	197%	37.1	9.9	273%	33.0	12.5	163%	21.9	9.9	122%
Cardiovascular Surgery (Urgent)	1.5	0.7	105%	1.6	1.1	45%	1.5	1.4	10%	1.5	1.5	1%	1.0	0.5	116%
Cardiovascular Surgery (Elective)	8.8	5.4	62%	5.9	6.0	-2%	3.6	5.8	-38%	4.0	5.0	-21%	3.5	3.4	4%
Urology	7.2	3.0	142%	3.4	2.4	39%	13.2	4.5	195%	2.6	3.0	-15%	3.6	2.5	46%
Internal Medicine	6.6	2.6	158%	8.6	3.6	136%	7.6	3.1	143%	4.1	2.9	42%	6.1	2.7	123%
Radiation Oncology	—	—	—	6.5	3.5	87%	6.3	5.3	18%	3.7	4.1	-9%	3.0	2.9	3%
Medical Oncology	1.0	2.0	-50%	3.5	2.6	32%	—	—	—	—	—	—	3.0	3.0	0%
Weighted Median	11.2	5.1	121%	8.6	4.9	76%	18.3	8.0	129%	9.6	5.9	62%	8.7	4.6	88%

Note: Percentage changes are calculated from exact weighted medians. The exact weighted medians have been rounded to one decimal place for inclusion in the table.

A = Median Actual Wait; R = Median Clinically Reasonable Wait; D = Percentage Difference

Table 10: Comparison between the Median Actual Weeks Waited and the Median Reasonable Number of Weeks to Wait for Treatment after Appointment with Specialist, by Selected Specialties, 2005

	Quebec			New Brunswick			Nova Scotia			Prince Edward Island			Newfoundland		
	A	R	D	A	R	D	A	R	D	A	R	D	A	R	D
Plastic Surgery	14.2	9.2	54%	28.0	14.1	98%	61.3	21.6	183%	25.8	12.0	115%	18.1	7.4	143%
Gynaecology	6.3	5.1	24%	13.4	7.6	76%	8.5	6.6	28%	4.5	9.3	-52%	4.1	3.7	9%
Ophthalmology	11.8	7.9	49%	11.2	8.9	25%	10.1	10.3	-2%	27.0	14.9	81%	9.7	8.6	12%
Otolaryngology	5.6	4.5	25%	13.0	7.8	68%	7.8	8.9	-12%	—	—	—	4.7	4.3	11%
General Surgery	5.9	4.2	42%	5.3	4.3	24%	8.0	3.8	109%	4.3	3.1	37%	14.4	4.6	210%
Neurosurgery	6.9	2.8	145%	17.8	7.7	132%	10.4	6.9	50%	—	—	—	5.1	—	—
Orthopaedic Surgery	20.3	9.9	105%	22.0	9.4	134%	35.2	16.8	110%	26.5	9.7	172%	11.7	7.8	51%
Cardiovascular Surgery (Urgent)	0.8	0.5	51%	1.3	1.3	6%	2.0	1.5	37%	6.0	2.0	200%	1.0	1.0	7%
Cardiovascular Surgery (Elective)	3.8	3.5	7%	7.2	6.9	3%	4.2	4.4	-4%	12.0	3.0	300%	51.5	5.1	916%
Urology	6.1	3.9	56%	7.3	6.3	16%	7.4	7.1	4%	—	—	—	8.3	4.3	95%
Internal Medicine	6.1	3.4	79%	14.0	5.1	176%	4.2	4.0	7%	5.8	3.2	79%	3.9	3.2	21%
Radiation Oncology	4.5	3.7	21%	3.1	5.7	-46%	3.0	3.3	-7%	6.1	3.1	96%	3.0	3.3	-10%
Medical Oncology	1.8	2.0	-11%	2.5	2.5	0%	3.3	2.9	15%	2.0	4.0	-50%	4.5	4.2	8%
Weighted Median	8.4	5.5	54%	11.6	7.0	65%	11.1	7.4	50%	10.7	6.3	69%	9.4	4.8	94%

Note: Percentage changes are calculated from exact weighted medians. The exact weighted medians have been rounded to one decimal place for inclusion in the table.

A = Median Actual Wait; R = Median Clinically Reasonable Wait; D = Percentage Difference

Table 11: Average Percentage of Patients Receiving Treatment Outside of Canada, 2005

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	0.8%	0.9%	1.2%	0.5%	1.2%	1.8%	0.0%	0.0%	0.0%	0.0%	1.1%
Gynaecology	1.9%	1.3%	0.6%	0.6%	1.2%	0.8%	0.2%	0.1%	—	0.0%	1.1%
Ophthalmology	1.1%	1.4%	0.2%	0.7%	1.9%	0.7%	0.2%	0.8%	2.5%	1.0%	1.3%
Otolaryngology	1.9%	1.3%	0.4%	1.0%	1.2%	0.3%	0.9%	0.1%	—	0.0%	1.0%
General Surgery	0.6%	0.6%	0.6%	0.4%	0.9%	0.3%	0.4%	0.6%	0.0%	0.3%	0.7%
Neurosurgery	0.4%	1.6%	0.1%	0.0%	2.2%	0.6%	5.0%	0.2%	—	5.0%	1.2%
Orthopaedic Surgery	1.8%	1.2%	0.6%	1.0%	1.1%	0.3%	2.0%	0.5%	0.0%	0.5%	1.1%
Cardiovascular Surgery	0.5%	0.7%	0.7%	0.0%	0.9%	0.0%	0.0%	0.3%	—	0.5%	0.6%
Urology	1.2%	2.4%	0.3%	0.3%	1.6%	0.1%	0.3%	0.1%	—	0.1%	1.1%
Internal Medicine	3.7%	1.1%	0.5%	1.0%	1.6%	0.8%	0.2%	0.1%	0.0%	0.0%	1.5%
Radiation Oncology	—	0.6%	0.5%	0.5%	1.8%	0.4%	1.7%	0.0%	0.0%	0.0%	1.2%
Medical Oncology	1.8%	2.5%	—	—	2.2%	1.8%	1.0%	0.2%	0.0%	1.7%	1.8%
All Specialties	1.7%	1.2%	0.5%	0.7%	1.4%	0.6%	0.9%	0.3%	0.5%	0.6%	1.1%

Table 12: Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist, by Specialty, 2005.

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Plastic Surgery	3,737	2,019	2,039	1,648	7,178	3,312	866	1,945	107	376
Gynaecology	4,328	3,120	2,146	2,054	9,077	5,123	1,475	1,158	87	398
Ophthalmology	10,810	4,740	8,123	1,379	46,661	57,140	2,151	2,841	443	821
Otolaryngology	2,914	1,819	4,025	1,067	8,228	3,154	1,393	687	—	336
General Surgery	8,507	5,141	3,689	1,424	23,629	17,636	1,039	2,831	231	3,343
Neurosurgery	848	448	218	113	2,374	1,448	334	212	—	94
Orthopaedic Surgery	21,194	11,317	6,237	6,750	38,552	16,039	3,109	5,278	512	779
Cardiovascular Surgery	294	182	64	76	510	329	42	46	13	16
Urology	6,038	2,108	3,466	376	11,279	12,624	1,025	2,302	—	1,190
Internal Medicine	4,710	4,946	1,972	873	15,332	12,019	949	917	176	579
Radiation Oncology	—	56	34	15	76	181	22	21	2	2
Medical Oncology	42	159	—	—	812	365	55	42	4	150
Residual	40,561	26,893	20,919	12,256	109,326	62,320	8,493	14,023	1,014	6,390
Total	103,983	62,948	52,931 ¹	28,031	273,035	191,690 ²	20,954 ³	32,303	2,587	14,475
Proportion of Population	2.51%	2.00%	5.32%	2.41%	2.23%	2.56%	2.79%	3.45%	1.87%	2.78%
Canada:	Total number of procedures for which patients are waiting in 2005								782,936	
	Percentage of Population								2.48%	

Note: Totals may not match sums of individual procedures or specialties due to rounding.

All data regarding oncology refer only to procedures done in hospitals. Most cancer patients are treated in cancer agencies. Therefore, the oncology data must be regarded as incomplete.

¹Saskatchewan Surgical Care Network web site reports 30,277 patients on wait lists for non-emergent surgery at March 31, 2005. For an extensive explanation, please refer to "Verification of current data with governments—Saskatchewan."

²Quebec Ministry of Health and Social Services reports 114,772 patients waiting for elective surgery at March 31, 2005.

³New Brunswick Health and Wellness reports 17,415 patients on wait lists for surgery at March 31, 2005.

Table 13a: Plastic Surgery (2005)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Mammoplasty	2,306	1,232	923	838	3,780	1,387	440	904	68	164
Neurolysis	183	244	63	171	1,228	693	48	57	24	74
Blepharoplasty	72	59	21	39	279	86	19	33	0	11
Rhinoplasty	440	97	540	131	594	298	113	178	6	63
Scar Revision	384	206	252	187	504	335	140	573	4	50
Hand Surgery	350	180	240	282	794	513	105	200	4	14
Total	3,737 ¹	2,019 ²	2,039 ³	1,648	7,178	3,312 ⁴	866 ⁵	1,945	107	376

Note: Totals may not match sums of individual procedures due to rounding.

¹BC Ministry of Health web site reports 4,337 patients waiting for plastic surgery at May 31, 2005.

²Alberta Health and Wellness reports 3,031 patients waiting for plastic surgery at April 30, 2005.

³Saskatchewan Surgical Care Network web site reports 2,065 patients on wait lists for non-emergent plastic and reconstructive surgery at March 31, 2005. For an extensive explanation, please refer to "Verification of current data with governments—Saskatchewan."

⁴Quebec Ministry of Health and Social Services reports 10,983 patients waiting for elective plastic surgery at March 31, 2005.

⁵New Brunswick Health and Wellness reports 1,967 people waiting for plastic surgery at March 31, 2005.

Table 13b: Gynaecology (2005)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Dilation & Curettage	598	787	167	203	1,616	996	107	212	11	78
Tubal Ligation	1,025	601	834	1,290	1,961	497	518	242	22	81
Hysterectomy (Vaginal/Abdominal)	1,490	819	675	261	2,627	1,671	567	348	35	83
Vaginal Repair	244	166	138	47	506	417	101	71	3	50
Tuboplasty	50	21	21	12	40	49	5	8	—	1
Laparoscopic Procedures	369	293	112	77	882	535	71	96	10	33
Hysteroscopic Procedures	553	433	198	163	1,445	959	107	181	6	72
Total	4,328 ¹	3,120 ²	2,146 ³	2,054	9,077	5,123 ⁴	1,475 ⁵	1,158	87	398

Note: Totals may not match sums of individual procedures due to rounding.

¹BC Ministry of Health web site reports 5,573 patients waiting for gynaecology at May 31, 2005.

²Alberta Health and Wellness reports 5,041 patients waiting for gynaecological surgery at April 30, 2005.

³Saskatchewan Surgical Care Network web site reports 2,702 patients on wait lists for non-emergent obstetrical and gynaecological surgery at March 31, 2005. For an extensive explanation, please refer to "Verification of current data with governments—Saskatchewan."

⁴Quebec Ministry of Health and Social Services reports 8,929 patients waiting for elective Gynaecological surgery at March 31, 2005.

⁵New Brunswick Health and Wellness reports 1,482 people waiting for gynaecology at March 31, 2005.

Table 13c: Ophthalmology (2005)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Cataract Removal	8,589 ¹	3,651 ²	7,452	1,061	38,903	52,882 ⁴	1,876	2,182	431	656
Cornea Transplant	383 ¹	268	31	84	506	351	0	99	—	—
Cornea—Pterygium	69	62	45	24	295	269	13	13	2	12
Iris, Ciliary Body, Sclera, Anterior Chamber	174	167	121	169	2,468	993	148	123	0	14
Retina, Choroid, Vitreous	776	307	105	—	1,917	538	2	270	0	29
Lacrimal Duct	223	63	61	5	594	825	40	45	2	39
Strabismus	281	42	33	—	1,069	663	30	71	0	21
Operations on Eyelids	315	180	275	35	909	618	42	38	8	49
Total	10,810 ¹	4,740 ²	8,123 ³	1,379	46,661	57,140 ⁴	2,151 ⁵	2,841	443	821

Note: Totals may not match sums of individual procedures due to rounding.

The procedure data reported generally includes only those procedures performed in public facilities. A large number of ophthalmological surgeries are performed in private facilities. The distribution of surgeries between public and private facilities varies significantly between provinces. There are also differences between provinces regarding payment or reimbursement for ophthalmological surgery at a private facility.

¹BC Ministry of Health web site reports 13,575 patients waiting for eye surgery (ophthalmology), 12,639 patients waiting for cataract surgery, and 548 patients waiting for corneal transplant at May 31, 2005.

²Alberta Health and Wellness reports 11,673 patients waiting for eye surgery and 9,426 waiting for cataract surgery at April 30, 2005.

³Saskatchewan Surgical Care Network web site reports 7,759 patients on wait lists for non-emergent eye surgery at March 31, 2005.

For an extensive explanation, please refer to “Verification of current data with governments—Saskatchewan.”

⁴Quebec Ministry of Health and Social Services reports 16,322 patients waiting for elective cataract surgery and 3,022 waiting for other ophthalmology at March 31, 2005.

⁵New Brunswick Health and Wellness reports 2,109 people waiting for ophthalmology at March 31, 2005.

Table 13d: Otolaryngology (2005)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Myringotomy	468	265	175	265	2,208	1,260	416	116	—	53
Tympanoplasty	191	38	614	37	305	241	116	81	—	9
Thyroid, Parathyroid, and Other Endocrine Glands	205	227	62	112	919	480	40	57	—	8
Tonsillectomy and/or Adenoidectomy	1,035	814	2,035	475	2,961	260	486	270	—	225
Rhinoplasty and/or Septal Surgery	408	56	467	83	550	308	67	56	—	14
Operations on Nasal Sinuses	607	420	672	95	1,285	605	269	107	—	27
Total	2,914 ¹	1,819 ²	4,025 ³	1,067	8,228	3,154 ⁴	1,393 ⁵	687	—	336

Note: Totals may not match sums of individual procedures due to rounding.

¹BC Ministry of Health web site reports 5,200 patients waiting for ear, nose, and throat surgery at May 31, 2005.

²Alberta Health and Wellness reports 4,126 patients waiting for ear, nose, and throat surgery at April 30, 2005.

³Saskatchewan Surgical Care Network web site reports 3,426 patients on wait lists for non-emergent ear, nose, and throat surgery at March 31, 2005. For an extensive explanation, please refer to “Verification of current data with governments—Saskatchewan.”

⁴Quebec Ministry of Health and Social Services reports 13,054 patients waiting for elective oto-rhino-laryngology at March 31, 2005.

⁵New Brunswick Health and Wellness reports 2,411 people waiting for otolaryngology at March 31, 2005.

Table 13e: General Surgery (2005)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Hernia/Hydrocele	2,215	691	889	280	3,392	1,970	310	565	61	685
Cholecystectomy	1,668 ¹	788 ²	703	216	2,450	2,598	266	436	25	483
Colonoscopy	2,256	1,725	855	432	10,195	8,493	98	981	75	1,855
Intestinal Operations	1,303	1,158	407	236	4,854	2,470	209	556	46	170
Haemorrhoidectomy	338	260	475	115	935	972	42	87	4	72
Breast Biopsy	26	22	23	9	73	49	5	58	1	8
Mastectomy	346	195	106	83	962	560	62	71	13	29
Bronchus and Lung	71	—	—	16	268	98	14	18	—	—
Aneurysm Surgery	15	6	0	1	68	74	—	—	—	1
Varicose Veins	268	297	230	37	432	353	34	58	4	42
Total	8,507 ¹	5,141 ²	3,689 ³	1,424	23,629	17,636 ⁴	1,039 ⁵	2,831	231	3,343

Note: Totals may not match sums of individual procedures due to rounding.

¹BC Ministry of Health web site reports 11,553 patients waiting for general surgery and 1,403 waiting for gall bladder surgery at May 31, 2005.

²Alberta Health and Wellness reports 6,358 patients waiting for general surgery and 893 patients waiting for gall bladder surgery (cholecystectomy) at April 30, 2005.

³Saskatchewan Surgical Care Network web site reports 3,495 patients on wait lists for non-emergent general surgery at March 31, 2005. For an extensive explanation, please refer to "Verification of current data with governments—Saskatchewan."

⁴Quebec Ministry of Health and Social Services reports 20,541 patients waiting for elective general surgery at March 31, 2005.

⁵New Brunswick Health and Wellness reports 2,986 people waiting for "General" at March 31, 2005.

Table 13f: Neurosurgery (2005)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Peripheral Nerve	78	65	12	31	488	168	33	15	—	40
Disc Surgery/ Laminectomy	423	248	118	41	1,040	975	241	57	—	27
Elective Cranial Bone Flap	300	126	85	38	806	270	55	135	—	28
Aneurysm Surgery	4	2	1	0	7	4	0	4	—	0
Carotid endarterectomy	43	5	1	2	33	33	4	1	—	—
Total	848 ¹	448 ²	218 ³	113	2,374	1,448 ⁴	334 ⁵	212	—	94

Note: Totals may not match sums of individual procedures due to rounding.

¹BC Ministry of Health web site reports 1,300 patients waiting for neurosurgery at May 31, 2005.

²Alberta Health and Wellness reports 553 patients waiting for neurosurgery at April 30, 2005.

³Saskatchewan Surgical Care Network web site reports 586 patients on wait lists for non-emergent neurosurgery at March 31, 2005. For an extensive explanation, please refer to "Verification of current data with governments—Saskatchewan."

⁴Quebec Ministry of Health and Social Services reports 1,005 patients waiting for elective neurosurgery at March 31, 2005.

⁵New Brunswick Health and Wellness reports 347 people waiting for neurosurgery at March 31, 2005.

Table 13g: Orthopaedic Surgery (2005)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Meniscectomy/Arthroscopy	1,393	616	399	197	2,039	1,370	260	583	42	117
Removal of Pins	1,077	587	252	277	1,897	1,396	221	288	15	42
Arthroplasty (Hip, Knee, Ankle, Shoulder)	15,250 ¹	8,289 ²	3,603	5,045	26,941	8,074	1,829	2,450	380	388
Arthroplasty (Interphalangeal, Metatarsophalangeal)	437	266	181	39	642	316	42	175	15	24
Hallux Valgus/Hammer Toe	155	21	125	67	392	139	45	64	6	8
Digit Neuroma	756	509	621	715	2,193	1,815	200	365	13	86
Rotator Cuff Repair	570	442	234	168	1,683	961	69	192	15	35
Ostectomy (All Types)	1,007	375	590	126	1,700	1,495	131	507	27	54
Routine Spinal Instability	550	212	232	117	1,066	473	313	654	0	25
Total	21,194 ¹	11,317 ²	6,237 ³	6,750	38,552	16,039 ⁴	3,109 ⁵	5,278	512	779

Note: Totals may not match sums of individual procedures due to rounding.

¹BC Ministry of Health web site reports 19,485 patients waiting for orthopaedic surgery, 2,922 waiting for hip replacement, and 5,288 waiting for knee replacement at May 31, 2005.

²Alberta Health and Wellness reports 12,127 patients waiting for orthopaedic surgery, 1,839 patients waiting for hip replacement, and 3,472 waiting for knee replacement at April 30, 2005.

³Saskatchewan Surgical Care Network web site reports 7,182 patients on wait lists for non-emergent orthopaedic surgery at March 31, 2005. For an extensive explanation, please refer to "Verification of current data with governments—Saskatchewan."

⁴Quebec Ministry of Health and Social Services reports 24,606 patients waiting for elective orthopaedic surgery at March 31, 2005.

⁵New Brunswick Health and Wellness reports 4,032 people waiting for orthopaedics at March 31, 2005.

Table 13h: Cardiovascular Surgery (2005)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Coronary Artery Bypass	102	82 ²	35	29	178	197	6	—	—	12
Valves & Septa of the Heart	65	39	12	9	91	56	2	—	—	2
Aneurysm Surgery	2	1	0	0	4	1	0	1	0	0
Carotid Endarterectomy	17	13	8	4	30	19	5	2	5	1
Pacemaker Operations	108	47	9	34	207	55	29	44	8	—
Total	294 ¹	182 ²	64 ³	76	510	329 ⁴	42 ⁵	46	13	16

Note: Totals may not match sums of individual procedures due to rounding.

¹BC Ministry of Health web site reports 370 patients waiting for cardiac surgery and 750 waiting for vascular surgery at May 31, 2005.

²Alberta Health and Wellness reports 1,589 patients waiting for cardiac, thoracic, and vascular surgery, and 277 patients waiting for coronary artery bypass surgery at April 30, 2005.

³Saskatchewan Surgical Care Network web site reports 229 patients on wait lists for non-emergent cardiovascular surgery at March 31, 2005. For an extensive explanation, please refer to "Verification of current data with governments—Saskatchewan."

⁴Quebec Ministry of Health and Social Services reports 3,339 patients waiting for elective cardiac, vascular, and thoracic surgery at March 31, 2005.

⁵New Brunswick Health and Wellness reports 69 people waiting for cardiac surgery and 140 people waiting for vascular surgery at March 31, 2005.

Table 13i: Urology (2005)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Non-radical Prostatectomy	862	188	1,121	41	997	668	70	143	—	109
Radical Prostatectomy	79	64	31	11	308	141	13	35	—	12
Transurethral Resection - Bladder	280	105	71	15	693	366	63	45	—	33
Radical Cystectomy	10	6	4	2	49	15	2	5	—	1
Cystoscopy	2,998	1,104	629	138	6,475	9,869	547	1,777	—	885
Hernia/Hydrocele	1,188	360	1,476	115	1,452	972	253	171	—	72
Bladder Fulguration	599	269	119	52	1,263	584	76	117	—	75
Ureteral Reimplantation for Reflux	22	12	17	1	43	10	1	10	—	3
Total	6,038 ¹	2,108 ²	3,466 ³	376	11,279	12,624 ⁴	1,025 ⁵	2,302	—	1,190

Note: Totals may not match sums of individual procedures due to rounding.

¹BC Ministry of Health web site reports 4,843 patients waiting for urology at May 31, 2005.

²Alberta Health and Wellness reports 2,463 patients waiting for urological surgery at April 30, 2005.

³Saskatchewan Surgical Care Network web site reports 1,633 patients on wait lists for non-emergent urological surgery at March 31, 2005. For an extensive explanation, please refer to "Verification of current data with governments—Saskatchewan."

⁴Quebec Ministry of Health and Social Services reports 8,433 patients waiting for elective urology at March 31, 2005.

⁵New Brunswick Health and Wellness reports 1,029 people waiting for urology at March 31, 2005.

Table 13j: Internal Medicine (2005)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Colonoscopy	2,858	4,022	1,274	659	11,971	9,877	80	638	138	396
Angiography /Angioplasty	1,598	524	603	140	1,846	1,031	838	193	21	106
Bronchoscopy	75	105	12	14	392	507	8	37	4	20
Gastroscopy	178	295	82	59	1,123	604	23	49	13	58
Total	4,710	4,946	1,972	873	15,332	12,019	949	917	176	579

Note: Totals may not match sums of individual procedures due to rounding.

Table 13k: Radiation Oncology (2005)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Radiotherapy	— ¹	56	34	15	76	181	22	21	2	2

All data regarding oncology refer only to procedures done in hospitals. Most cancer patients are treated in cancer agencies. Therefore, the oncology data must be regarded as incomplete.

¹BC Ministry of Health web site reports 320 patients waiting for radiotherapy at May 31, 2005.

Table 13l: Medical Oncology (2005)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Chemotherapy	42	159	—	—	812	365	55	42	4	150

All data regarding oncology refer only to procedures done in hospitals. Most cancer patients are treated in cancer agencies. Therefore, the oncology data must be regarded as incomplete.

Table 14: Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist (2005)—Procedures per 100,000 Population

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Plastic Surgery	90	64	205	142	59	44	115	208	77	72
Gynaecology	104	99	216	177	74	68	196	124	63	76
Ophthalmology	261	150	816	119	381	763	286	304	321	158
Otolaryngology	70	58	405	92	67	42	185	73	—	65
General Surgery	205	163	371	122	193	236	138	302	167	643
Neurosurgery	20	14	22	10	19	19	44	23	—	18
Orthopaedic Surgery	511	359	627	580	315	214	414	564	371	150
Cardiovascular Surgery	7	6	6	7	4	4	6	5	9	3
Urology	146	67	348	32	92	169	136	246	—	229
Internal Medicine	114	157	198	75	125	161	126	98	128	111
Radiation Oncology	—	2	3	1	1	2	3	2	1	0
Medical Oncology	1	5	—	—	7	5	7	5	3	29

All data regarding oncology refer only to procedures done in hospitals. Most cancer patients are treated in cancer agencies. Therefore, the oncology data must be regarded as incomplete.

Table 15: Comparison of Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist, by Selected Specialties, 2004 and 2005

	British Columbia			Alberta			Saskatchewan			Manitoba			Ontario		
	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg
Plastic Surgery	3,737	3,267	14%	2,019	1,758	15%	2,039	2,200	-7%	1,648	1,286	28%	7,178	6,389	12%
Gynaecology	4,328	4,724	-8%	3,120	3,519	-11%	2,146	2,047	5%	2,054	2,231	-8%	9,077	9,992	-9%
Ophthalmology	10,810	11,386	-5%	4,740	4,623	3%	8,123	9,420	-14%	1,379	1,633	-16%	46,661	52,203	-11%
Otolaryngology	2,914	4,509	-35%	1,819	1,787	2%	4,025	4,963	-19%	1,067	764	40%	8,228	11,634	-29%
General Surgery	8,507	8,177	4%	5,141	4,850	6%	3,689	5,116	-28%	1,424	1,784	-20%	23,629	19,758	20%
Neurosurgery	848	741	14%	448	512	-13%	218	335	-35%	113	72	58%	2,374	2,801	-15%
Orthopaedic Surgery	21,194	19,026	11%	11,317	10,083	12%	6,237	13,203	-53%	6,750	3,701	82%	38,552	31,713	22%
Cardiovascular Surgery	294	372	-21%	182	350	-48%	64	79	-19%	76	28	172%	510	517	-1%
Urology	6,038	5,667	7%	2,108	2,369	-11%	3,466	3,574	-3%	376	1,005	-63%	11,279	12,145	-7%
Internal Medicine	4,710	3,682	28%	4,946	5,828	-15%	1,972	1,478	33%	873	661	32%	15,332	12,516	23%
Radiation Oncology	—	23	—	56	38	49%	34	18	87%	15	9	56%	76	139	-45%
Medical Oncology	42	59	-30%	159	313	-49%	—	—	—	—	—	—	812	1,067	-24%
Residual	40,561	39,260	3%	26,893	26,749	1%	20,919	26,550	-21%	12,256	10,213	20%	109,326	110,355	-1%
Total	103,983	100,895	3%	62,948	62,777	0%	52,931	68,984	-23%	28,031	23,386	20%	273,035	271,230	1%

Note: Percentage changes are calculated from exact calculated estimates, which have been rounded for inclusion in the table.

All data regarding oncology refer only to procedures done in hospitals. Most cancer patients are treated in cancer agencies. Therefore, the oncology data must be regarded as incomplete.

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Table 15: Comparison of Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist, by Selected Specialties, 2004 and 2005

	Quebec			New Brunswick ¹			Nova Scotia			Prince Edward Island			Newfoundland		
	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg
Plastic Surgery	3,312	3,836	-14%	866	1,332	-35%	1,945	1,172	66%	107	111	-4%	376	810	-54%
Gynaecology	5,123	5,408	-5%	1,475	1,074	37%	1,158	970	19%	87	178	-51%	398	397	0%
Ophthalmology	57,140	70,991	-20%	2,151	961	124%	2,841	2,492	14%	443	266	66%	821	546	50%
Otolaryngology	3,154	3,524	-11%	1,393	1,512	-8%	687	630	9%	—	—	—	336	393	-15%
General Surgery	17,636	16,714	6%	1,039	2,297	-55%	2,831	1,366	107%	231	632	-64%	3,343	978	242%
Neurosurgery	1,448	1,497	-3%	334	480	-30%	212	111	90%	—	—	—	94	65	45%
Orthopaedic Surgery	16,039	16,358	-2%	3,109	2,685	16%	5,278	4,547	16%	512	853	-40%	779	984	-21%
Cardiovascular Surgery	329	340	-3%	42	126	-66%	46	112	-59%	13	—	—	16	22	-27%
Urology	12,624	15,053	-16%	1,025	7,239	-86%	2,302	1,763	31%	—	68	—	1,190	1,198	-1%
Internal Medicine	12,019	10,587	14%	949	2,066	-54%	917	1,080	-15%	176	415	-57%	579	847	-32%
Radiation Oncology	181	378	-52%	22	29	-22%	21	15	39%	2	0	956%	2	6	-61%
Medical Oncology	365	387	-6%	55	43	29%	42	23	82%	4	4	-15%	150	204	-26%
Residual	62,320	71,130	-12%	8,493	11,435	-26%	14,023	11,064	27%	1,014	1,566	-35%	6,390	5,022	27%
Total	191,690	216,204	-11%	20,954	31,278 ²	-33%	32,303	25,344	27%	2,587	4,093	-37%	14,475	11,471	26%

¹2005 figures for New Brunswick are based on procedures counts from discharge data for 2003-04. Figures published in the 14th edition of *Waiting Your Turn* were based on estimates of procedures counts built from hospitalization data for 1999-2000 and procedures counts for other provinces for 2002-03. Because of the change from an estimation methodology to a true historical count methodology, the 2005 estimates of the numbers of procedures for which patients are waiting are not directly comparable with the previously published numbers. The 2004 estimates of procedures for which patients are waiting have been presented in this edition of *Waiting Your Turn*, but the changes between 2004 and 2005 should be interpreted with caution.

²New Brunswick Health and Wellness reports 16,063 patients on surgical waiting lists in March, 2004, and 17,415 at March 31, 2005—an increase of 8.4 percent.

Note: Percentage changes are calculated from exact calculated estimates, which have been rounded for inclusion in the table.

All data regarding oncology refer only to procedures done in hospitals. Most cancer patients are treated in cancer agencies. Therefore, the oncology data must be regarded as incomplete.

Table 16a: Acute Inpatient Procedures, 2003-04 (Part I)

Procedure	BC	AB	SK	ON	NB	NS	PE	NL
Arthroplasty (Hip, Knee, Ankle, Shoulder)	9,548	7,604	2,877	29,959	2,165	2,526	357	994
Arthroplasty (Interphalangeal/Metatarsophalangeal)	537	382	112	868	79	70	4	48
Hallux Valgus/Hammer Toe	160	104	59	369	47	19	2	12
Menisectomy/Arthroscopy	254	247	109	645	75	62	6	48
Ostectomy	1,788	2,011	489	4,697	340	497	18	172
Removal of Pins	960	1,013	234	2,805	188	178	20	98
Rotator Cuff Repair	581	632	145	1,708	90	163	13	88
Routine Spinal Instability	893	964	287	2,841	313	326	0	107
Bladder Fulguration	1,328	1,345	1,026	4,635	412	543	43	257
Cystoscopy	2,365	1,615	1,098	9,252	580	1,630	125	872
Non-radical Prostatectomy	3,661	1,466	723	7,879	534	883	126	280
Radical Cystectomy	126	102	26	422	29	60	6	19
Radical Prostatectomy	824	720	219	2,669	146	227	52	107
Transurethral Resection—Bladder	1,131	880	448	4,171	389	209	46	226
Ureteral Reimplantation for Reflux	75	72	34	243	3	27	5	7
Cataract Removal	206	266	107	387	35	81	12	32
Cornea Transplant	41	84	30	55	0	11	6	7
Cornea—Pterygium	1	2	0	8	0	9	0	0
Iris, Ciliary Body, Sclera, Anterior Chamber	208	266	121	430	9	138	3	26
Lacrimal Duct Surgery	71	81	63	112	15	34	0	38
Operations on Eyelids	217	171	67	497	31	65	3	23
Retina, Choroid, Vitreous	1,915	4,448	500	3,513	10	551	5	304
Strabismus Surgery	13	18	81	109	3	8	0	2
Myringotomy	290	331	82	748	283	146	20	145
Operations on Nasal Sinuses	605	774	67	994	196	264	31	188
Thyroid, Parathyroid, and Other Endocrine Glands	1,384	1,487	351	5,514	339	349	21	209
Tonsillectomy and/or Adenoidectomy	1,576	1,654	1,046	2,517	1,388	570	171	811
Tympanoplasty	130	147	15	409	92	123	5	32
Radiotherapy	605	392	281	1,215	289	357	14	42
Chemotherapy	1,987	1,785	808	10,643	1,145	644	84	529
Breast Biopsy	119	81	31	256	16	19	1	13
Bronchus and Lung	824	700	240	3,007	247	360	25	104

Source: Canadian Institute for Health Information, "All Procedures Performed, by Province and CCI code, 2003-04," and Fiscal 2004/05 CCI to CCP Conversion Tables.

Note: Information is not available in this format for Quebec, and is incomplete for Manitoba.

Table 16a: Acute Inpatient Procedures, 2003-04 (Part II)

Procedure	BC	AB	SK	ON	NB	NS	PE	NL
Cholecystectomy	4,137	4,179	1,953	8,088	1,651	1,530	369	1,132
Haemorrhoidectomy	104	93	70	275	34	23	4	20
Intestinal Operations	7,088	5,350	1,967	20,749	1,619	2,421	313	1,169
Mastectomy	2,623	2,183	724	5,239	557	641	137	366
Varicose Veins	89	202	98	168	42	48	12	28
Disk Surgery/Laminectomy	1,638	1,066	410	4,998	303	225	7	224
Elective Cranial Bone Flap	2,382	2,568	735	6,935	472	584	0	382
Blepharoplasty	12	12	3	53	0	4	0	2
Mammoplasty	1,246	1,097	393	3,145	540	164	36	173
Scar Revision	938	1,152	237	1,508	118	199	12	112
Coronary Artery Bypass	2,659	2,027	898	9,268	579	1,088	0	642
Pacemaker Operations	4,545	1,642	623	8,349	707	697	58	809
Valves & Septa of the Heart	1,650	1,606	312	4,662	234	452	0	128
Angiography/Angioplasty	6,560	5,395	2,450	20,756	1,537	1,913	37	955
Bronchoscopy	694	1,413	227	4,082	109	417	15	234
Gastroscopy	514	882	266	3,481	332	308	41	241
Dilation and Curettage	562	437	118	1,166	93	46	14	89
Hysterectomy	6,458	4,850	1,691	16,940	1,838	1,804	314	1,075
Hysteroscopic Procedures	160	227	63	442	43	48	5	34
Laparoscopic Procedures	761	413	157	1,558	109	127	26	78
Tubal Ligation	1,552	1,502	799	4,511	508	459	115	255
Tuboplasty	99	67	22	127	6	4	2	4
Vaginal Repair	638	633	164	2,204	244	250	16	376
Rhinoplasty and/or Septal Surgery	484	348	47	683	142	172	26	126
Hernia/Hydrocele	4,779	4,232	2,244	19,418	1,337	1,655	275	843
Carotid Endarterectomy	817	334	127	1,323	127	80	44	67
Hand Surgery/Digit Neuroma	403	372	107	913	71	62	5	80
Neurolysis/Peripheral Nerve	416	480	111	3,116	114	85	4	58
Colonoscopy	2,826	2,891	1,301	10,612	770	804	151	840
Aneurysm Surgery	209	182	34	608	20	72	0	13
Residual	88,813	82,544	25,410	264,651	43,150	26,209	2,101	14,347
Total	180,279	162,223	55,537	533,605	66,894	53,740	5,363	30,742

Source: Canadian Institute for Health Information, "All Procedures Performed, by Province and CCI code, 2003-04," and Fiscal 2004/05 CCI to CCP Conversion Tables.

Note: Information is not available in this format for Quebec, and is incomplete for Manitoba.

Table 16b: Same Day Procedures, 2003-04 (Part I)

Procedure	BC	SK	ON	NB	NS	PE	NL
Arthroplasty (Hip, Knee, Ankle, Shoulder)	5,137	1,584	16,738	1,005	659	207	268
Arthroplasty (Interphalangeal/Metatarsophalangeal)	598	112	1,220	103	158	19	56
Hallux Valgus/Hammer Toe	315	96	1,328	146	114	16	37
Meniscectomy/Arthroscopy	4,272	878	8,190	1,276	1,104	176	561
Ostectomy	830	241	2,668	280	256	22	63
Removal of Pins	2,541	495	5,417	450	420	46	215
Rotator Cuff Repair	1,067	261	3,761	207	362	41	138
Routine Spinal Instability	0	0	2	0	1	0	0
Bladder Fulguration	3,465	622	11,788	378	977	26	299
Cystoscopy	23,618	8,241	102,978	3,482	9,921	561	4,879
Non-radical Prostatectomy	823	15	763	27	45	0	3
Transurethral Resection—Bladder	2,507	258	4,838	269	458	15	58
Ureteral Reimplantation for Reflux	0	5	34	0	25	0	0
Cataract Removal	37,015	11,636	100,760	8,093	9,373	760	3,069
Cornea Transplant	433	0	768	0	161	0	2
Cornea—Pterygium	446	129	1,269	60	76	7	79
Iris, Ciliary Body, Sclera, Anterior Chamber	920	402	10,264	954	926	17	81
Lacrimal Duct Surgery	897	200	2,464	159	200	2	56
Operations on Eyelids	1,833	528	5,409	409	313	26	404
Retina, Choroid, Vitreous	6,580	1,322	21,405	102	2,261	18	206
Strabismus Surgery	1,204	136	2,817	127	402	0	95
Myringotomy	2,754	1,733	16,916	1,521	1,583	258	1,225
Operations on Nasal Sinuses	2,024	451	7,361	580	241	50	374
Thyroid, Parathyroid, and Other Endocrine Glands	40	10	458	6	22	0	3
Tonsillectomy and/or Adenoidectomy	2,907	221	16,727	718	705	70	358
Tympanoplasty	697	372	1,574	242	258	7	164
Radiotherapy	218	1	110	86	0	0	0
Chemotherapy	160	389	3,502	2	20	10	1,213
Breast Biopsy	427	376	1,014	110	985	35	186
Bronchus and Lung	46	2	94	0	13	1	3
Cholecystectomy	3,406	658	17,391	653	1,306	68	599
Haemorrhoidectomy	1,361	1,166	7,828	206	430	47	353

Source: Canadian Institute for Health Information, "All Procedures Performed, by Province and CCI code, 2003-04," and Fiscal 2004/05 CCI to CCP Conversion Tables.

Note: Information is not available in this format for Alberta and Quebec, and is incomplete for Manitoba.

Table 16b: Same Day Procedures, 2003-04 (Part II)

Procedure	BC	SK	ON	NB	NS	PE	NL
Intestinal Operations	9,849	3,011	42,353	1,098	2,396	374	1,781
Mastectomy	4,572	1,111	11,440	1,059	845	206	629
Varicose Veins	840	243	3,039	177	269	44	52
Disk Surgery/Laminectomy	54	27	410	45	20	0	0
Elective Cranial Bone Flap	20	5	54	5	3	0	0
Blepharoplasty	223	64	1,396	30	31	1	33
Mammoplasty	1,952	293	5,044	236	254	11	40
Scar Revision	311	61	675	69	193	6	18
Pacemaker Operations	1,076	283	2,431	56	438	7	146
Valves & Septa of the Heart	38	10	68	1	2	0	0
Angiography/Angioplasty	6,227	1,732	3,247	643	322	86	417
Bronchoscopy	608	86	2,710	57	349	25	290
Gastroscopy	1,032	479	8,195	101	543	84	510
Dilation and Curettage	7,209	1,617	19,841	832	1,529	190	1,541
Hysterectomy	0	65	137	4	5	0	3
Hysteroscopic Procedures	4,633	1,226	12,080	574	1,126	101	713
Laparoscopic Procedures	1,636	349	5,497	198	499	87	189
Tubal Ligation	3,777	1,009	12,486	1,176	1,117	124	677
Tuboplasty	118	6	135	6	18	2	4
Vaginal Repair	418	112	1,083	85	86	10	57
Rhinoplasty and/or Septal Surgery	2,714	784	5,069	229	306	24	123
Hernia/Hydrocele	8,806	2,030	22,564	1,773	2,395	256	943
Carotid Endarterectomy	0	0	0	0	0	0	0
Hand Surgery/Digit Neuroma	3,759	1,078	10,673	767	1,214	71	631
Neurolysis/Peripheral Nerve	783	194	4,319	162	334	101	780
Colonoscopy	31,443	11,919	144,584	625	10,819	1,930	8,693
Aneurysm Surgery	3	1	6	0	2	0	0
Residual	97,474	32,765	380,683	50,005	38,863	2,840	24,078
Total	298,116	93,100	1,078,075	81,664	97,753	9,085	57,395

Source: Canadian Institute for Health Information, "All Procedures Performed, by Province and CCI code, 2003-04," and Fiscal 2004/05 CCI to CCP Conversion Tables.

Note: Information is not available in this format for Alberta and Quebec, and is incomplete for Manitoba.

Appendix 1: Psychiatry Waiting List Survey (3rd Edition)

With each passing week, it becomes more obvious that the deterioration in Canada's public health care program is not confined to just the twelve medical specialties examined in the main text of *Waiting Your Turn*, or in the five priority areas now being focused on by governments across the country. In particular, there has been an increasing amount of anecdotal evidence presented in the media about the long waiting times that psychiatry patients experience. Further, many patients and media representatives have come to The Fraser Institute in search of more complete information on waiting times for these services. Such data is typically not available from local or regional governments for this specialty, and where it is available, it is not comparable across jurisdictions. We responded to this absence in 2003 by adding psychiatry to the annual measurement of waiting lists reported in *Waiting Your Turn*, thus creating the first national, comprehensive, and comparable measurement of waiting times for mental health services available in Canada.

Information on the performance of the health care system is rare in Canada, and patients with mental health concerns desire the same access to information that is available for those with physical ailments in both *Waiting Your Turn* and through some provinces' health ministries.

Methodology

The psychiatry waiting list survey was conducted between January 10 and April 8, 2005. Surveys were sent out to all of the specialists in the psychiatry category of the Canadian Medical Association's membership rolls who have allowed their names to be provided by Cornerstone List Fulfillment. Due to the large population of psychiatrists in Ontario, a 50 percent sample was taken in the cities of Hamilton (92, 46 surveyed), London (94, 47 surveyed), North York (87, 44 surveyed), Ottawa (217 specialists, 109 surveyed), and Toronto (625, 313 surveyed). As is the practice with the traditional 12 specialties surveyed in *Waiting Your Turn*, psychiatrists in Quebec and New Brunswick who indicate that their language of preference is French were sent French-language surveys. The response rate to the psychiatry survey was 16 percent overall in 2005, a decrease of 6 percent from 2004, and ranged from 35 percent in Saskatchewan to 14 percent in British Columbia, Manitoba, and Quebec (table A1).

The treatments identified in the following tables represent a cross-section of common treatments carried out by psychiatrists. The list of treatments was developed in consultation with the Canadian Psychiatric Association, who also assisted in making adjustments to the standard survey form to reflect differences between psychiatric practices and practices in the other specialties presented in this document.

Table A1: Summary of Responses

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	Can
Mailed	518	274	40	137	1,129	963	32	112	6	36	3,247
Number of Responses	74	57	14	19	190	131	5	29	0	6	525
Response Rates	14%	21%	35%	14%	17%	14%	16%	26%	0%	17%	16%

Table A2: Psychiatry (2005)—Median Patient Wait to See a Specialist after Referral from a GP

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	Can
Urgent	2.0	2.0	2.3	2.0	2.0	1.5	6.0	1.0	—	2.0	1.9
Elective	8.0	8.0	10.0	8.0	8.0	7.0	20.0	6.0	—	12.0	7.8

The major findings from the psychiatry survey can be found in tables A2 through A7. Table A2 reports the median time a patient waits to see a specialist after referral from a general practitioner. Waiting times are presented for both urgent and elective referrals. Table A3 summarizes the second stage of waiting, that between the decision by a specialist that treatment is required and the treatment being received. Table A4 provides the percentage change in median waits to receive treatment after the first appointment with a specialist between the years 2004 and 2005.

Unlike other specialties in *Waiting Your Turn* in which the waiting times are weighted by the total number of such procedures that have been done by all physicians, the overall median for psychiatry is presented as an unweighted measure (see the section on *Methodology* for a clear description of The Fraser Institute's weighting procedures). All of the median measures that make up the final specialty median are given equal weight. This alteration to the standard methodology results from a lack of data counting the number of patients treated by psychiatrists, separated by treatment. We hope, in the coming years, to develop a weighting system for psychiatric treatments to allow a weighted average for this specialty to be calculated. In the current estimates, national medians are developed through a weighting system that bases the weight of each provincial median on the number of specialists in that province.

Table A5 summarizes clinically "reasonable" waiting times for psychiatric treatments. The times presented here are the medians of physicians' estimates of clinically reasonable lengths of time to wait for treatment after an appointment with a specialist. The methodol-

ogy for calculating an overall median is described above. Table A6 compares the actual and clinically reasonable wait times after an appointment with a specialist.

Finally, table A7 provides waiting times for diagnostic technologies used by psychiatrists. Though two of these technologies (CT and magnetic resonance imaging (MRI)) are also used by specialists in the other 12 specialties, the wait times for psychiatrists' access to these services has been presented separately in order to allow for any fundamental differences that may exist in the wait times between physical and mental health services.⁴

Survey results: estimated waiting in Canada

The total waiting time for psychiatric treatment is composed of two segments: waiting after being referred by a general practitioner before consultation with a psychiatrist, and subsequently, waiting to receive treatment after the first consultation with a psychiatrist. The 2005 psychiatry survey provides details of waiting for each segment.

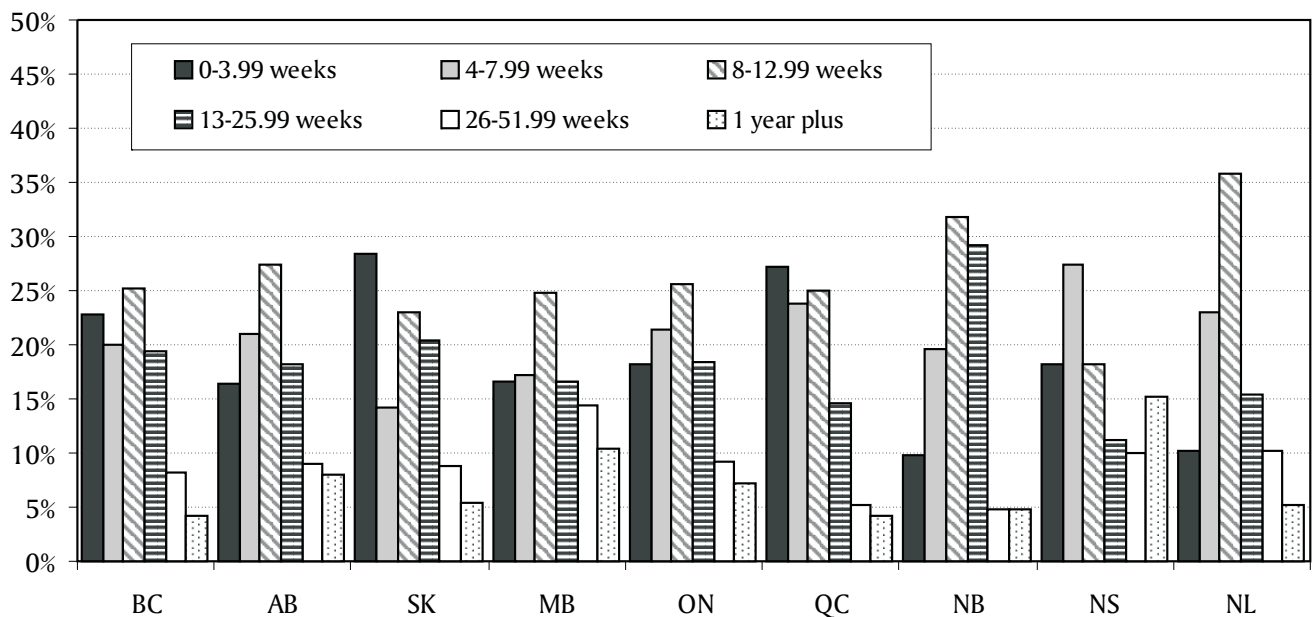
Table A2 indicates the number of weeks that patients wait for initial appointments with psychiatrists after referral from their general practitioners or from other specialists. The waiting time to see a psychiatrist on an urgent basis was 1.9 weeks in Canada, ranging from 1.0 week in Nova Scotia to 6.0 weeks in New Brunswick. The waiting time for referrals on an elective basis for Canada as a whole was 7.8 weeks. The longest waiting times for elective referrals was in New Brunswick

4 For comparison, the overall Canadian median waiting time for CT scans was 5.5 weeks in the traditional 12 specialties and 5.4 weeks in the psychiatry survey, with a mean absolute difference (the average of absolute differences between the two measures) of 1.4 weeks for 9 provinces. The overall Canadian median waiting time for MRIs in the psychiatry survey was 13.8 weeks, compared to 12.2 weeks for the other 12 specialties. The mean absolute difference in this case, again for 9 provinces, was 5.1 weeks.

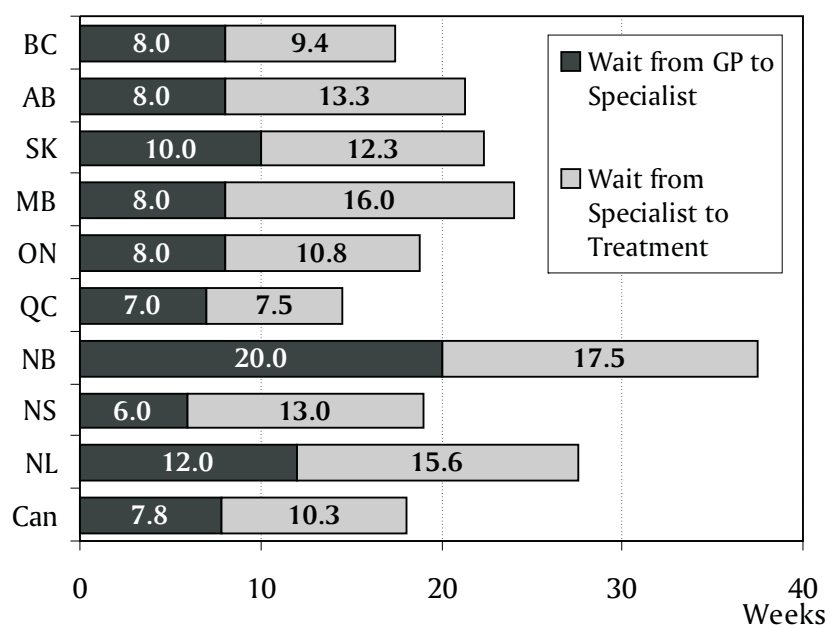
Table A3: Psychiatry (2005)—Median Patient Wait for Treatment after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	Can
Initiate a course of brief psychotherapy	6.0	7.0	7.0	8.0	8.0	6.0	12.0	8.0	—	11.0	7.1
Initiate a course of long-term psychotherapy	12.0	12.0	11.0	16.0	14.0	12.0	12.0	14.0	—	19.5	13.0
Initiate a course of pharmacotherapy	4.0	3.0	2.5	4.0	4.0	3.0	3.5	3.5	—	4.0	3.6
Initiate a course of couple/marital therapy	8.0	9.5	24.0	8.0	10.0	8.0	10.0	6.0	—	16.0	9.1
Initiate cognitive behaviour therapy	6.3	8.0	9.0	11.0	9.0	8.0	10.0	6.5	—	10.0	8.2
Access a day program	6.0	8.0	8.0	7.0	6.0	4.0	12.0	13.0	—	7.0	6.0
Access an eating disorders program	15.0	12.0	12.0	12.0	12.0	11.0	10.0	10.0	—	10.0	12.1
Access a housing program	14.0	25.0	3.0	15.0	24.0	6.0	37.0	12.0	—	11.5	16.1
Access an evening program	8.0	12.0	7.0	6.0	12.0	8.0	52.0	12.0	—	—	10.2
Access a sleep disorders program	20.0	45.0	40.0	65.0	8.0	12.0	24.0	52.0	—	40.0	19.1
Access assertive community treatment or similar program	4.5	5.0	12.0	24.0	12.0	5.0	10.5	6.0	—	27.0	8.6
Unweighted Median	9.4	13.3	12.3	16.0	10.8	7.5	17.5	13.0	—	15.6	10.3

Graph A1: Frequency Distribution of Survey Waiting Times (Specialist to Treatment) by Province, 2005



Graph A2: Weeks Waited from Referral by GP to Treatment, by Province, 2005



(20.0 weeks), followed by Newfoundland (12.0 weeks), and Saskatchewan (10.0 weeks). The shortest wait for an elective referral was in Nova Scotia (6.0 weeks), followed by Quebec (7.0 weeks), and British Columbia, Alberta, Manitoba, and Ontario (8.0 weeks).

within 8 weeks (51.1%). Waits of 26 weeks or more are least frequent in Quebec (9.4%) and most frequent in Nova Scotia (25.1%).

Table A3 summarizes the waiting time for certain psychiatric treatments after an appointment with a specialist. The longest waiting times for this second segment of the total waiting time were found in New Brunswick (17.5 weeks), Manitoba (16.0 weeks), and Newfoundland (15.6 weeks), while the shortest waits were found in Quebec (7.5 weeks), British Columbia (9.4 weeks), and Ontario (10.8 weeks). Among the treatments, patients waited longest to enter a sleep disorders program (19.1 weeks) or a housing program (16.1 weeks), while the wait times were shortest for pharmacotherapy (3.6 weeks), and admission to a day program (6.0 weeks).

Graph A1 presents a frequency distribution of the survey responses by province and by region. In all provinces the wait for the majority of treatments is less than 13 weeks. Quebec performs the highest proportion of treatments within 13 weeks (76.0 percent) and

Table A4i: Comparison of Median Weeks Waited to Receive Treatment after Appointment with Specialist, by Province, 2004 and 2005

	British Columbia			Alberta			Saskatchewan			Manitoba			Ontario		
	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg
Psychiatry	9.4	10.6	-11%	13.3	13.2	1%	12.3	11.0	12%	16.0	13.1	22%	10.8	9.7	11%

Note: Percentage changes are calculated from exact weighted medians. The exact weighted medians have been rounded to one decimal place for inclusion in the table.

Table A4ii: Comparison of Median Weeks Waited to Receive Treatment after Appointment with Specialist, by Province, 2004 and 2005

	Quebec			New Brunswick			Nova Scotia			Prince Edward Island			Newfoundland		
	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg	2005	2004	% chg
Psychiatry	7.5	9.7	-22%	17.5	7.6	130%	13.0	14.8	-12%	—	36.7	—	15.6	11.1	40%

Note: Percentage changes are calculated from exact weighted medians. The exact weighted medians have been rounded to one decimal place for inclusion in the table.

Table A5: Psychiatry (2005)—Median Reasonable Patient Wait for Treatment after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	Can
Initiate a course of brief psychotherapy	3.0	4.0	3.0	4.0	4.0	4.0	3.0	4.0	—	3.0	3.8
Initiate a course of long-term psychotherapy	6.0	5.0	4.5	7.0	6.0	6.0	4.0	6.0	—	5.0	5.9
Initiate a course of pharmacotherapy	2.0	2.0	1.0	2.0	2.0	2.0	1.5	3.0	—	2.0	2.0
Initiate a course of couple/marital therapy	4.0	4.0	6.0	4.0	4.0	4.0	2.0	4.0	—	4.0	4.0
Initiate cognitive behaviour therapy	3.3	4.0	4.0	3.5	4.0	4.0	3.0	4.0	—	4.0	3.8
Access a day program	2.5	3.0	1.8	2.0	2.3	2.3	4.0	6.0	—	3.5	2.5
Access an eating disorders program	4.0	4.0	4.0	4.0	3.5	4.0	2.0	4.0	—	3.0	3.8
Access a housing program	4.0	4.0	2.3	3.3	4.0	3.5	3.5	4.5	—	3.0	3.8
Access an evening program	4.0	4.0	4.5	4.5	4.0	4.0	2.0	3.0	—	—	4.0
Access a sleep disorders program	4.0	4.0	8.0	4.5	4.0	6.0	4.0	7.0	—	12.0	4.9
Access assertive community treatment or similar program	2.0	2.3	4.0	3.5	4.0	3.0	2.3	3.8	—	4.3	3.2
Unweighted Median	3.5	3.7	3.9	3.8	3.8	3.9	2.8	4.5	—	4.4	3.8

Table A4 compares the 2004 and 2005 waiting times for treatment. This year's study indicates an overall increase in the waiting time between consultation with a specialist and treatment in 6 provinces, with decreases in British Columbia (11%), Quebec (22%), and Nova Scotia (12%). At the same time, between 2004 and 2005, the median wait increased by 1 percent in Alberta, 12 percent in Saskatchewan, 22 percent in Manitoba, 11 percent in Ontario, 130 percent in New Brunswick, and 40 percent in Newfoundland.

While the data on these two segments of waiting time convey only partial impressions about the extent of health care rationing, a fuller picture is provided by information on the sum of these two segments, the total waiting time. This overall wait records the time between the referral by a general practitioner and the time that the required treatment is begun. For Canada as a whole, the total waiting time in 2005 for psychiatry remained unchanged from 2004 at 18.1 weeks (Graph A2). The shortest waiting times were recorded in Quebec (14.5 weeks), British Columbia (17.4 weeks),

and Ontario (18.8 weeks). The longest total waits were found in New Brunswick (37.5 weeks), Newfoundland (27.6 weeks), and Manitoba (24.0 weeks).

Finally, physicians responding to the survey are asked to provide a clinically reasonable waiting time for the various treatments. Specialists generally indicated a period of time substantially shorter than the median number of weeks patients were actually waiting for treatment (see tables A5 and A6). Table A5 summarizes the reasonable waiting times for psychiatric treatments and is based on the same methodology used to create table A3. All of the actual median waiting times for treatments (in table A3) are greater than the clinically reasonable median waiting times (in table A5). For the specialty of psychiatry, Quebec came closest to meeting the standard of "reasonable," in that the actual specialist-to-treatment waits only exceeded the corresponding "reasonable" value by 94 percent, a smaller gap than in the other provinces. The differences between the median reasonable and median

Table A6: Psychiatry (2005)—Difference Between Actual and Reasonable Patient Waits for Treatment after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	Can
Initiate a course of brief psychotherapy	100%	75%	133%	100%	100%	50%	300%	100%	—	267%	86%
Initiate a course of long-term psychotherapy	100%	140%	144%	129%	133%	100%	200%	133%	—	290%	120%
Initiate a course of pharmacotherapy	100%	50%	150%	100%	100%	50%	133%	17%	—	100%	77%
Initiate a course of couple/marital therapy	100%	138%	300%	100%	150%	100%	400%	50%	—	300%	126%
Initiate cognitive behaviour therapy	92%	100%	125%	214%	125%	100%	233%	63%	—	150%	113%
Access a day program	140%	167%	357%	250%	167%	78%	200%	117%	—	100%	138%
Access an eating disorders program	275%	200%	200%	200%	243%	175%	400%	150%	—	233%	218%
Access a housing program	250%	525%	33%	362%	500%	71%	957%	167%	—	283%	323%
Access an evening program	100%	200%	56%	33%	200%	100%	2500%	300%	—	—	158%
Access a sleep disorders program	400%	1025%	400%	1344%	100%	100%	500%	643%	—	233%	293%
Access assertive community treatment or similar program	125%	122%	200%	586%	200%	67%	367%	60%	—	535%	169%
Unweighted Median	168%	264%	215%	317%	185%	94%	518%	190%	—	257%	171%

actual wait for psychiatric treatments are summarized in table A6.

Finally, patients would also prefer earlier treatment, according to this year's survey data. On average, only 4.0 percent of patients are on waiting lists because they have requested a delay or postponement of their treatment. Conversely, the proportion of patients who would have begun their treatment within a few days if it were available is 80.3 percent (The Fraser Institute, national hospital waiting list survey, 2005).

A note on technology

The wait to see a specialist and the wait to receive treatment are not the only waits that patients face. The psychiatry portion of the national waiting list survey also examines the wait that mental health patients have for various diagnostic technologies across Canada. Table A7 displays the median number of weeks patients must wait for access to a CT or MRI scanner, or

an electroencephalogram (EEG). Compared to 2004, waiting times for both CT and MRI scans fell in 2005, while the waiting time for an EEG was unchanged. The median wait for a CT scan across Canada was 5.4 weeks, ranging from a high of 7.0 weeks (Newfoundland), to a low of 2.0 weeks (New Brunswick). The median wait for an MRI across Canada was 13.8 weeks. Patients in Newfoundland waited the longest (48.0 weeks), while patients in New Brunswick waited the least amount of time (6.0 weeks). Finally, the median wait for an EEG across Canada was 3.8 weeks. Residents of New Brunswick faced the shortest waits for an EEG (1.5 weeks), while residents of Alberta, Manitoba, Ontario, Quebec, and Newfoundland waited longest (4.0 weeks).

Conclusion

The information documented here suggests that patients seeking mental health treatment are likely to be disappointed with their access to it. With waiting

Table A7: Waiting for Technology: Weeks that Mental Health Patients Waited to Receive Selected Diagnostic Tests in 2003, 2004, and 2005

Province	CT-Scan			MRI			EEG		
	2005	2004	2003	2005	2004	2003	2005	2004	2003
British Columbia	4.5	4.3	6.0	8.0	13.5	13.0	3.0	3.0	3.0
Alberta	5.0	7.0	4.0	16.0	14.0	14.0	4.0	4.0	4.0
Saskatchewan	5.0	6.0	9.5	37.0	38.0	14.0	3.5	4.0	5.0
Manitoba	3.3	9.5	6.0	10.0	14.0	8.0	4.0	5.0	2.8
Ontario	6.0	6.0	5.0	15.5	14.0	16.0	4.0	4.0	4.0
Quebec	6.0	6.0	6.0	13.5	16.0	12.0	4.0	4.0	4.0
New Brunswick	2.0	7.5	5.0	6.0	9.0	11.0	1.5	4.0	2.8
Nova Scotia	3.0	2.5	3.0	8.0	12.0	22.0	2.5	2.5	3.3
P.E.I.	—	1.0	30.0	—	—	45.0	—	1.0	6.0
Newfoundland	7.0	4.0	12.0	48.0	32.0	22.0	4.0	3.0	4.3
Canada	5.4	5.8	5.4	13.8	14.9	14.4	3.8	3.8	3.8

times nearing 5 months from a general practitioner to treatment, and with wait times from a meeting with a specialist to treatment that are nearly three times longer than specialists feel is appropriate, it is clear that a

great many patients in need of psychiatric attention are facing the effects of rationing in our health care system and experiencing a deterioration of their condition before they get the care they need.

Appendix 2: The Fraser Institute National Waiting List Survey

General Surgery

Please circle the province in which your office is located:

AB BC MB NB NL NS NT NU ON PE QC SK YT

- From today, how long (in weeks) would a new patient have to wait for a routine office consultation with you?
_____ week(s)
- Do you restrict the number of patients waiting to see you in any manner? (i.e. Do you accept referrals only at certain times of the year?)
 Yes No
- Over the past 12 months, what percentage of the surgical procedures you performed were done on a day surgery basis?
_____ %
- From today, how long (in weeks) would a new patient have to wait for the following types of elective surgery or diagnostic procedures? What would you consider to be a clinically reasonable waiting time for these types of surgery and procedures?

Surgery or Procedure	Number of Weeks to Wait	Reasonable Number of Weeks to Wait
Hernia repair (all types)/hydrocele		
Cholecystectomy		
Colonoscopy (diagnostic)		
Incision, excision, anastomosis of intestine and other operations on intestine		
Haemorrhoidectomy/other anal surgery		
Breast biopsy		
Mastectomy/segmental resection		
Operations on bronchus and lung		
Incidentally discovered and unruptured aneurysms		
Varicose vein surgery		

5. Has the length of your waiting lists changed since last year at this time?

- Increased Decreased Remained the Same

6. If the length of your waiting lists has changed, what are the major reasons for the change?
(Check all which may be applicable.)

- _____ Availability of O/R nurses
 _____ Availability of other technical staff
 _____ Availability of beds
 _____ Availability of O/R time
 _____ Change in patient load
 _____ Availability of ancillary investigations or consultations (i.e. MRI, CT scans)
 _____ Other

7. What percentage of your patients currently waiting for surgery are on a waiting list primarily because **they** requested a delay or postponement?

_____ %

8. What percentage of your patients currently waiting for surgery do you think would agree to having their surgery within the week if an opening arose in O/R?

_____ %

9. To the best of your knowledge, what percentage of your patients that are listed on hospital waiting lists might also be listed by other physicians for the same procedure?

_____ %

10. Do you use the following types of diagnostic tests? If so, how long (in weeks) would a new patient have to wait for these tests?

Do you use this diagnostic test?	Yes	No	Infrequently	Number of weeks patients wait
CT Scan				
MRI				
Ultrasound				

11. Approximately what percentage of your patients **inquired** in the past 12 months about the availability of medical services:

In another province? _____ % Outside of Canada? _____ %

12. Approximately what percentage of your patients **received** non-emergency medical treatment in the past 12 months:

In another province? _____ % Outside of Canada? _____ %

Thank you very much for your cooperation.

Appendix 3: Glossary of Terms

Aneurysm Surgery: a surgical procedure to correct a localized abnormal dilatation of a blood vessel, usually an artery, due to a congenital defect or a weakness in the wall of the vessel.

Angiography/Angioplasty: **angiography** is the diagnostic or therapeutic radiography of the heart and blood vessels using a radiopaque (impenetrable to x-rays or other forms of radiation) contrast medium (types include magnetic resonance imaging, interventional radiology, and computed tomography), and an **angioplasty** is the alteration of a blood vessel, either surgically or by dilating the vessel using a balloon inside the lumen (the space within an artery or vein).

Arthroplasty: plastic surgery to reshape or reconstruct a diseased joint (“interphalangeal” refers to a joint between two phalanges, i.e., fingers or toes).

Bladder Fulguration: destruction of bladder tissue by means of high-frequency electric sparks.

Blepharoplasty: plastic surgery on the eyelid.

Bronchoscopy: examination of the bronchi through a bronchoscope (an endoscope designed to pass through the trachea for visual inspection of the tracheobronchial tree).

Bronchus: the bronchus, or windpipe, is one of the two large branches of the trachea.

Carotid Endarterectomy: a surgical technique for removing intra-arterial obstructions of the lower cervical portion of the internal carotid artery (one of two arteries that comprise the principal blood supply to the head and neck).

Cataract Removal: removal of a cataract (i.e., opacity of the lens of the eye, its capsule, or both).

Cholecystectomy: excision of the gallbladder by abdominal incision or laparoscopy.

Colonoscopy: examination of the upper portion of the rectum with an elongated speculum or a colonoscope (an instrument for examining the colon).

Cornea—Pterygium: triangular thickening of the bulbar conjunctiva extending from the inner canthus (eye

slit) to the border of the cornea with the apex toward the pupil.

Cornea Transplant: transplant of the cornea (transparent anterior portion of the fibrous outer layer of the eyeball composing about one-sixth of its surface).

Craniofacial Procedures: procedures concerning the head and the face.

Cystectomy: removal of a cyst; excision of the cystic duct and the gallbladder, or just the cystic duct; excision of the urinary bladder or a part of it.

Cystoscopy: examination of the bladder with a cystoscope (an instrument for interior examination of the bladder and ureter).

Digit Neuroma: a neuroma (i.e., a tumour composed of nerve cells) affecting a digit (finger or toe).

Dilation and Curettage: a surgical procedure that expands the cervical canal of the uterus (dilation) so that the surface lining of the uterine wall can be scraped (curettage).

Disk Surgery/Laminectomy: a laminectomy is the excision of a vertebral posterior arch, usually to remove a lesion or herniated disc.

Gastrosocopy: examination of the stomach and abdominal cavity using a gastroscope (an endoscope for inspecting the stomach’s interior).

Glaucoma: a group of eye diseases characterized by increased intraocular pressure, resulting in atrophy of the optic nerve and possibly leading to blindness.

Hallux Valgus: displacement of the big toe toward the other toes.

Haemorrhoidectomy: the removal of haemorrhoids by one of several techniques including surgery, cryotherapy, infrared photocoagulation, laser surgery, or ligation by use of rubber bands applied to the base of the haemorrhoid.

Hernia/Hydrocele: a **hernia** is a protrusion or projection of an organ or part of an organ through the wall of the cavity that normally contains it, and a **hydrocele** is the accumulation of a serous fluid in a saclike cavity.

Hysterectomy: surgical removal of the uterus through the abdominal wall or vagina.

Hysteroscopic Procedures: procedures involving inspection of the uterus by the use of a special endoscope called a hysteroscope (an instrument for examining the uterine cavity).

Iris/Ciliary Body/Sclera/Anterior Chamber: **iris** (the coloured contractile membrane suspended between the lens and the cornea in the aqueous humour of the eye, separating the anterior and posterior chambers of the eyeball and perforated in the centre by the pupil); **ciliary muscle** (the smooth muscle forming a part of the ciliary body of the eye: contraction pulls the choroid forward, lessening tension on the fibres of the zonula (suspensory ligament) and allowing the lens, which is elastic, to become more spherical: accommodation for near vision is accomplished by this process); and, **sclera** (the outer layer of the eyeball made of fibrous connective tissue: at the front of the eye, it is visible as the white of the eye and ends at the cornea, which is transparent).

Lacrimal Duct: tear duct.

Laparoscopic Procedures: procedures involving abdominal exploration using a laparoscope (an endoscope designed to permit visual examination of the abdominal cavity).

Mammoplasty: plastic surgery of the breast.

Mastectomy: excision of the breast.

Meniscectomy/Arthroscopy: a **meniscectomy** is the removal of meniscus cartilage of the knee, and **arthroscopy** is the direct visualization of a joint by means of an arthroscope (an endoscope for examining the interior of a joint).

Myringotomy: incision of the tympanic membrane (of the ear).

Neurolysis: the stretching of a nerve to relieve pain; the loosening of adhesions surrounding a nerve; the disintegration or destruction of nerve tissue.

Ostectomy: surgical excision of a bone or a portion of one.

Peripheral Nervous System: the portion of the nervous system outside the central nervous system.

Prostatectomy: excision of part or all of the prostate gland (radical is the complete removal, while non-radical is a partial removal).

Retina/Choroid/Vitreous: **retina** (the innermost layer of the eye, which receives images transmitted through the lens and contains the receptors for vision, the rods and cones); **choroid** (the dark blue vascular layer of the eye between the sclera and the retina, extending from the ora serrata to the optic nerve: it consists of blood vessels united by connective tissue containing pigmented cells and contains five layers); and, **vitreous body** (a transparent jelly-like mass composed of collagen fibrils and a gel (vitreous humour): it fills the cavity of the eyeball, behind the lens and in front of the retina).

Rhinoplasty and/or Septal Surgery: **rhinoplasty** is plastic surgery of the nose, and **septal surgery** is a surgical procedure on the nasal septum, i.e., the wall dividing the two nasal cavities.

Strabismus: a disorder of the eye in which optic axes cannot be directed to the same object: the squinting eye always deviates to the same extent when the eyes are carried in different directions.

Thyroid and Other Endocrine Glands: the **thyroid** is an endocrine gland in the neck, anterior to and partially surrounded by the thyroid cartilage and upper rings of the trachea, and **endocrine glands** are ductless glands that produce an internal secretion discharged into the blood or lymph and circulated to all parts of the body (hormones, the active principles of the glands, affect tissues more or less remote from their place of origin).

Tonsillectomy and/or Adenoidectomy: a **tonsillectomy** is the surgical removal of the tonsils and an **adenoidectomy** is the excision of the adenoids.

Tubal ligation: surgery to tie the fallopian tubes (through which ova and spermatozoa travel).

Tuboplasty: plastic repair of a fallopian tube or tubes in an attempt to restore patency so that fertilization of the ovum may occur.

Tympanoplasty: any one of several surgical procedures designed either to cure a chronic inflammatory process in the middle ear or to restore function to the sound-transmitting mechanism of the middle ear.

Varicose vein: an enlarged, twisted superficial vein.

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Government and Government Agency Maintained Wait List Web Sites

British Columbia Ministry of Health

www.healthservices.gov.bc.ca/cpa/mediasite/waittime/waittimes.html

Alberta Ministry of Health and Wellness

www.health.gov.ab.ca/waitlist/WaitListPublicHome.jsp

Saskatchewan Surgical Care Network

www.sasksurgery.ca

Manitoba Ministry of Health

www.gov.mb.ca/health/waitlist/

Ontario Ministry of Health and Long-Term Care

www.health.gov.on.ca/transformation/wait_times/wait_mn.html

Cardiac Care Network of Ontario

www.ccn.on.ca/access.html

Cancer Care Ontario—Radiation Treatment

www.cancercare.on.ca/index_waittimesRadiation.asp

Cancer Care Ontario—Systemic Therapy (Chemotherapy)

www.cancercare.on.ca/index_waittimessystemic.asp

Quebec Ministry of Health and Social Services

www.msss.gouv.qc.ca/sujets/listesdattente/index.html