

October 2011

Why We Wait

Physician Opinions on Factors Affecting Health Care Wait Times

by Bacchus Barua

Main Conclusions

- In 2010, specialist physicians surveyed across 12 specialties and 10 Canadian provinces were asked to report changes to the length of their waiting lists, and choose the reason for the change from a list they were given
- The most frequently reported reasons for increases were “availability of operating room time,” “change in patient load,” and “availability of beds”
- The most frequently reported reasons for decreases were “other,” “availability of operating room time,” and “change in patient load”
- Overall, the most frequently reported reasons responsible for any change in waiting lists (either an increase or decrease) were “availability of operating room time,” “change in patient load,” and “other”
- Between 2000-01 and 2010, “availability of operating room time” has consistently been the most commonly reported determinant of how long patients may have to wait for medically necessary elective treatment with “change in patient load” being the second most commonly reported determinant. On the other hand, “availability of technical staff” is the least commonly reported reason for changes in waiting lists
- The findings of this paper, coupled with the reality that Canadians had to wait 12 percent longer in 2010 than they did in 2000-01, implies that these reasons, beyond being those most commonly cited by physicians as responsible for changes in their waiting lists, may actually be methods by which access to health care is being rationed.

Introduction

It has become fairly common knowledge that patients in Canada have to wait an inordinately long time for access to health care (see, for example, Barua and Rovere, 2011). The Fraser Institute report from 2010, *Waiting Your Turn: Wait Times for Health Care in Canada*, found that while physicians believed a 6.4-week wait was reasonable for medically necessary elective¹ treatment after an appointment with a specialist, on average, Canadians actually waited for 9.3 weeks (Barua et al., 2010).² Further, a recent article examining the findings of the Canadian Institute for Health Information's report on wait times demonstrated that in 2010-2011, approximately 80,000 Canadians didn't get access to priority treatment areas within the lengthy government benchmarks for wait times (Skinner, 2011).

If governments understand the importance of reining in wait times,³ and more importantly, if physicians themselves acknowledge that patients are waiting longer than is medically reasonable, what is

preventing physicians from providing medical services more expediently?

Physicians' responses to the Fraser Institute's annual wait times survey may provide some insight. In addition to measuring the length of wait times, the survey asks doctors the following questions:

- a) Has the length of your waiting lists changed since last year at this time?
 - Increased
 - Decreased
 - Stayed the same
- b) If the length of your waiting lists has changed, what are the major reasons for the change? Options for response (check all that apply):
 - Availability of operating room (O/R) nurses
 - Availability of other technical staff
 - Availability of beds
 - Availability of operating room (O/R) time
 - Change in patient load
 - Availability of ancillary investigations or consultations (ie., Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scans)
 - Other (please specify)

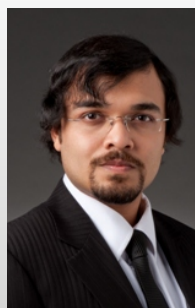
rate of 16%). Of those, 1,610 replied to the question, "Has the length of your waiting lists changed since last year at this time?" Slightly over 40 percent of them indicated that their waiting lists had increased, about 15 percent indicated that their lists had decreased, and slightly more than 44 percent said that their waiting lists had stayed the same over the year (Barua et al., 2010).

As table 1 shows, of the 654 surveys where respondents indicated that wait times had increased in 2010, "Availability of O/R time" was the most frequently⁴ cited reason, appearing in 67.9 percent of these surveys, followed by "Change in patient load" (38.8 percent), and "Availability of beds" (29.5 percent).

By comparison, table 2 shows that of the 243 surveys where respondents indicated that wait times had decreased in 2010, "Other" was the most frequently cited reason, appearing in 38.7 percent of these surveys, followed by "Availability of O/R time" (37.5 percent) and "Change in Patient Load" (30.5 percent).

Whether their waiting lists rose or fell, physicians had the same selection of reasons from which to attribute the changes in their lists. In an effort to identify the most commonly reported indicators of overall change, the two results were aggregated; of the 897 surveys that indicated either an increase or a decrease in waiting time in 2010,⁵ "Availability of O/R time" was the most frequently cited reason, appearing in 59.6 percent of these surveys, followed by "Change in patient load," at 36.6 percent, and "Other" at 26.9 percent (see table 3).

About the author



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Selected results from our survey

The 2010 *Waiting Your Turn* survey received 1,667 responses from Canadian physicians (a response

Table 1: Reasons cited for an increase in wait times between 2009 and 2010

Reason	Frequency	Percent ¹ = (Frequency/Total surveys indicating increase ²)
Availability of operating room nurses	166	25.4
Availability of other technical staff	43	6.6
Availability of beds	193	29.5
Availability of operating room time	444	67.9
Change in patient load	254	38.8
Availability of ancillary investigations/consultations	76	11.6
Other	147	2.5

¹Percentages will not add up to 100 as respondents could indicate more than one reason per survey.

²654 surveys indicated an increase in wait times.

Table 2: Reasons cited for a decrease in wait times between 2009 and 2010

Reason	Frequency	Percent ¹ = (Frequency/Total surveys indicating decrease ²)
Availability of operating room nurses	26	10.7
Availability of other technical staff	14	5.8
Availability of beds	14	5.8
Availability of operating room time	91	37.5
Change in patient load	74	30.5
Availability of ancillary investigations/consultations	15	6.2
Other	94	38.7

¹Percentages will not add up to 100 as respondents could indicate more than one reason per survey.

²243 surveys indicated a decrease in wait times.

Table 3: Reasons cited for any change (increase or decrease) in wait times between 2009 and 2010

Reason	Frequency	Percent ¹ = (Frequency/Total surveys indicating increase or decrease ²)
Availability of operating room nurses	192	21.4
Availability of other technical staff	57	6.4
Availability of beds	207	23.1
Availability of operating room time	535	59.6
Change in patient load	328	36.6
Availability of ancillary investigations/consultations	91	10.1
Other	241	26.9

¹Percentages will not add up to 100 as respondents could indicate more than one reason per survey.

²897 surveys indicated either an increase or decrease in wait times.

Table 4: Reason most often selected as responsible for change (by province), 2009-2010

	Increase	Decrease	Either
Alberta	OR time	OR time / Other	OR time
British Columbia	OR time	Other	OR time
Manitoba	OR time	OR time	OR time
New Brunswick	OR time	Patient load	OR time / Patient load
Newfoundland & Labrador	Patient load	Other	Patient load
Nova Scotia	OR time	Patient load	OR time
Ontario	OR time	OR time	OR time
Prince Edward Island	Patient load	OR time / Other	OR time / Patient load
Quebec	OR time	Other	OR time
Saskatchewan	Patient load	OR time	OR time

Note: Where two reasons are given in a cell, both were cited with equal frequency.

Provincial and medical specialty breakdowns

A breakdown of the provincial results from the 2010 study reveals that with few exceptions, “Availability of operating room time” and “Change in patient load” are the most frequently cited factors responsible for changes (increases or decreases) in waiting lists for all provinces.

When the results are broken down by medical specialty, “Availability of

operating room time,” “Change in patient load,” and “Other” are commonly cited by most specialists. However, “Availability of technical staff” is the reason most frequently cited by radiation oncologists for changes (increases or decreases) in their 2010 patient waiting lists.

Analyzing the most frequently reported reasons for change

One of the frequently reported reasons for an increase or decrease in waiting lists is “Change in patient load.” Patient load changes can occur due to any number of factors, including changes in the prevalence of illness, changes to physician remuneration, etc.,⁶ the corroboration of which is beyond the scope of this article. However, some explanation may be provided by examining Canada’s physician supply, which has been deemed insufficient to

meet demand under the current system (Esmail, 2011). Although data indicate that the physician-to-population ratio has been slowly rising over the past decade (OECD, 2011), it is possible that demographic factors including both Canada’s aging population⁷ and Canada’s aging physician population⁸ have contributed towards increasing the burden on the country’s already overloaded physicians. (Canada only had 2.3 physicians per 1,000 people in 2008, ranking it 28th out of 34 OECD countries (OECD 2011; calculations by author⁹).

Another factor influencing wait times, according to survey respondents, is the availability of beds. At only 1.8 curative beds per 1,000 people, which ranks Canada 31st out of 32 OECD countries in 2008 (OECD 2011; calculations by author¹⁰), it may be the case that the current stock of beds is unable to keep pace with increasing demand. Unfortunately, evidence also suggests

Acknowledgements

The author would like to acknowledge the important contributions of Nadeem Esmail, Mark Rovere, and Brett Skinner. He is also grateful to several external reviewers for their helpful comments and suggestions.

Table 5: Reason most often selected for change (by medical specialty), 2009-2010

Specialty	Increase	Decrease	Either
Orthopaedics	OR time	OR time	OR time
Urology	OR time	Patient load	OR time
Ophthalmology	OR time	OR time	OR time
Otolaryngology	OR time	OR time	OR time
Radiation Oncology	Tech staff / Patient load	Tech staff / Other	Tech staff
Medical Oncology	Patient load	Other	Other
General Surgery	OR time	Other	OR time
Neurosurgery	OR time	Patient load	OR time
Plastic Surgery	OR time	Patient load	OR time
Cardiovascular	OR time / Avail beds	Patient load	OR time / Patient Load
Internal Medicine	Patient load	Other	Patient load / Other
Gynaecology	OR time	OR time / Other	OR time

Note: Where two reasons are given in a cell, both were cited with equal frequency.

that the few beds that Canadians do have access to aren't necessarily being used efficiently. For example, 15 percent of Ontario's acute and other in-patient care beds were occupied by alternative-levels-of-care (ALC) patients in April 2011 (Ontario Hospital Association, 2011). These are patients who continue to occupy an acute care hospital bed after the acute phase of their inpatient stay is complete (Wait Time Alliance, 2011: 10) and are simply "awaiting an alternative level of care in a more appropriate setting" (Walker et al., 2009: 1). This means that almost "one in six beds is filled with patients who should be cared for somewhere else" (Wait Time Alliance, 2011: 10).

Finally, survey respondents most frequently cited the availability of operating room time as an overall

factor affecting wait times. This factor is complex. News stories and anecdotal evidence citing a lack of operating room time abound (see Chisholm, 2011, for example). However, an investigation conducted by the Montreal Economic Institute examining the use of 49 percent of the operating rooms in public hospitals from April 2005 to March 2006 found that not only was there an average of nearly one closed operating room per hospital, but the rate of use of open operating rooms was only 46 percent during weekday day shifts. Further, while 62 percent of operating rooms were open during weekday evenings, they were used at only 9 percent of their capacity. On weekends, the O/R opening rate fell to 45 percent, and the rate they were used fluctuated between 6 and 8 percent (Frappier and Laberge, 2007).

Such underuse might seem puzzling, given that 67.9 percent of physicians who said that their waiting lists increased in 2010 attributed this increase to a lack of operating room time. However, one can speculate that their response probably reflects the underlying problems that play into one another to create the situation.¹¹ For example, as physicians with increasing patient loads demand more O/R time, a lack of O/R nurses¹² may result in less time when operating rooms can function; fewer beds might mean capping the number of patients a hospital can schedule for surgery in a day, etc., all of which may result in less operating room time (even if an operating room is open and available).

Indeed, expanding the analysis to include data from 2000/01 to 2010¹³ shows that operating room time

availability has long been the most frequently cited reason for physician-reported increases in wait times (figure 1), one of the most prominently cited reasons that led to decreases in wait times (figure 2), and overall the most commonly reported determinant of how long patients may have to wait for medically necessary elective surgery (figure 3).

The long-term trends in reported factors affecting wait times shown in the figures also indicate what may be some signs of improvement. For example, while the availability of O/R nurses was cited in 40.8 percent of cases where respondents indicated an increase in waiting time in 2000-01, this number fell to 25.4 percent in 2010 (figure 1). At the same time, where respondents indicated a decrease in waiting time in 2000-01, this reason was cited in 6.1 percent of cases, which rose to 10.7 percent in 2010 (figure 2). This may be partially explained by the fact that both the registered nurse (RN) and licensed practitioner nurse (LPN) workforces grew at rates exceeding that of the Canadian population between 2005 and 2009 (4.9 percent of the RN and 1.3 percent of the LPN workforce were involved in providing direct care in the operating room in 2009) (Canadian Institute for Health Information, 2010).

A brief international comparison

Canada spent approximately 10.3 percent of its gross domestic product on its health care system in 2008, making it the 6th most expensive among 34 OECD countries, not

Figure 1: Reasons for increase in waiting times

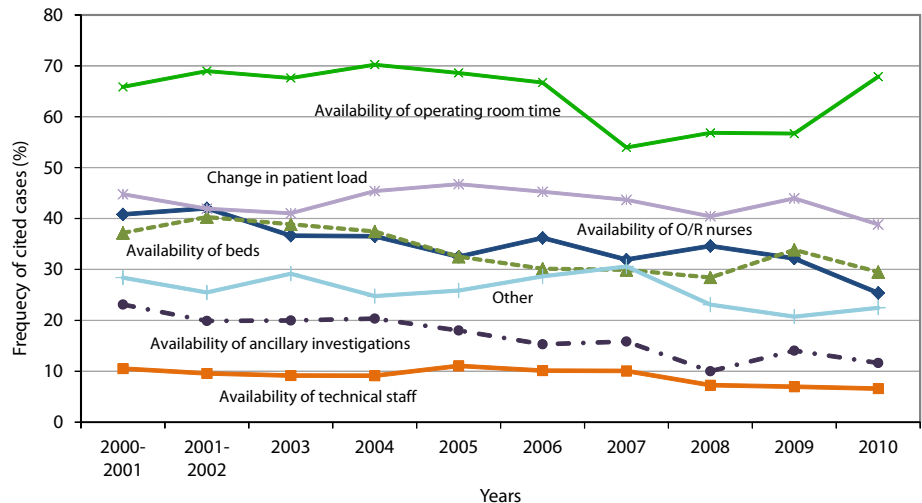


Figure 2: Reasons for decrease in waiting times

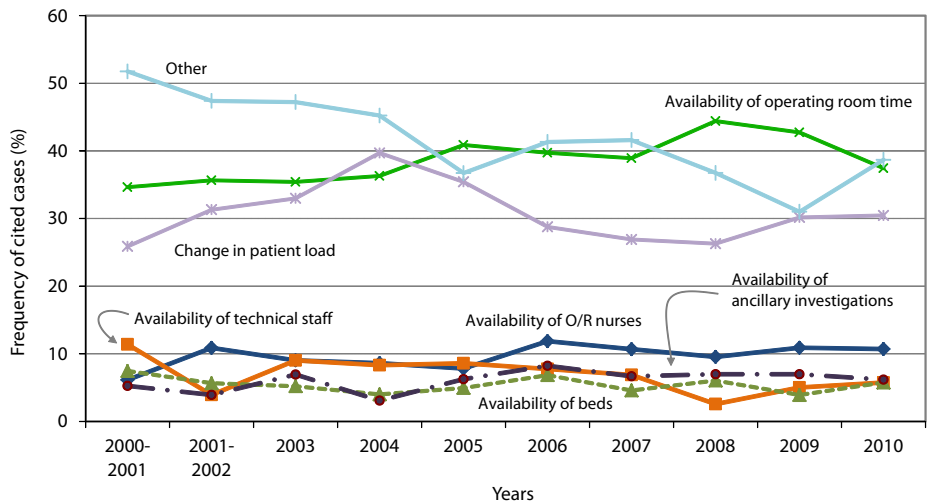
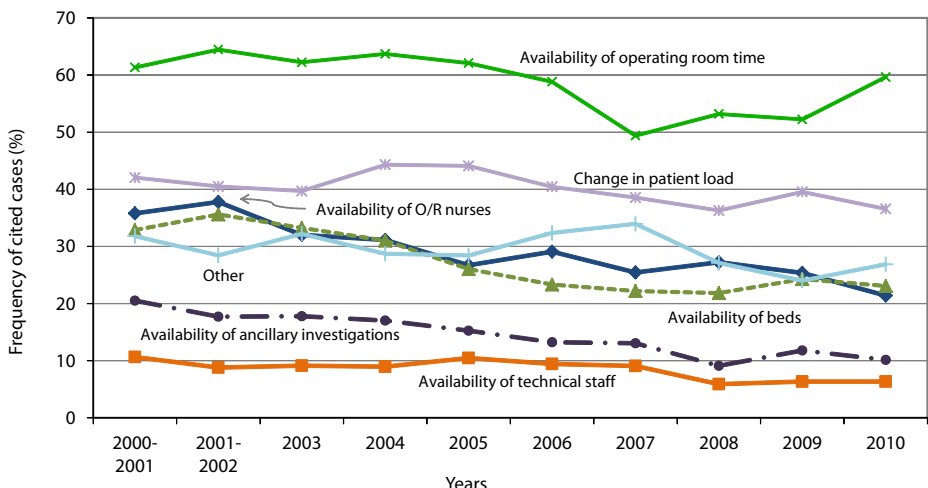


Figure 3: Reasons for change in waiting times



adjusted for age¹⁴ (OECD, 2011; calculations by author). This funding level indicates that the long wait times that Canadians endure are hardly the result of an underfunded system, but rather due to inefficiencies within the system itself.

Indeed, an international comparison conducted by the Commonwealth Fund using survey data from 2007 to 2009 found that, compared to Australia, Germany, New Zealand, the Netherlands, the United Kingdom, and the United States, “Canada ranks last, or next to last on almost all measures of timeliness of care” (Davis, Schoen, and Stremikis, 2010: 11).¹⁵ Only two of these countries, the United States and Germany, spent more than Canada on health care (unadjusted for age) as a percentage of GDP in 2008 (OECD, 2011).

Conclusion

The decade’s worth of survey responses presented in this paper indicate that physicians consider the availability of operating room time and a changing patient load, at the very least, to strongly affect the lengths of their waiting lists. Consequently, these are potential areas for policymakers to focus on.

It is noteworthy that the number of physicians citing the availability of operating room time and a changing patient load in conjunction with an increase in their waiting lists far outweighs physicians who cite those factors in conjunction with a decrease in their lists. This fact, coupled with the reality that Canadians had to wait 12 percent longer in 2010 (Barua et al., 2010) than they

did in 2000-01 (Walker and Wilson, 2001)¹⁶ for medically necessary elective treatment (after referral from a general practitioner) gives credence to the notion that these reasons, beyond being those most commonly cited by physicians as responsible for changes in their waiting lists, may actually be methods by which access to health care is being rationed.¹⁷

Notes

1 Elective surgeries (those not considered emergencies) vary in their medical necessity. For example, while cataract removal or hysterectomy may be considered medically necessary (though elective), a cosmetic facelift is not.

2 The report also found that the average Canadian could face a total wait of 18.2 weeks between referral from a general practitioner and receipt of medically necessary elective treatment.

3 For example, Canada’s provincial, territorial, and federal governments agreed to a set of common benchmarks for medically necessary treatment on December 12, 2005 (Ontario Ministry of Health and Long Term Care, 2005).

4 A “Related Samples Cochran Q Test,” using a .05 level of significance, was performed on separate data sets containing cases where physicians indicated an increase in waiting lists, decrease in waiting lists, as well as a combined data set of the two. In each of the three individual tests, the null hypothesis that the distributions of the cited reasons (availability of O/R nurses, availability of other technical staff, etc.) were the same, was rejected. A more detailed analysis revealed that for *some* pair-wise comparisons, the null hypothesis that the two reasons in question had the same distribution was *not* rejected. This, however, is not surprising as there is every possibility that some reasons cited might be correlated (the formal analysis of which is beyond the scope of this paper).

5 There were 713 survey respondents who indicated that their waiting lists remained the same as the previous year.

6 For example, approximately 67 percent of Canada’s specialist physicians cited “Increasing complexity of patient caseload” as a factor responsible for “increasing the demand for the physician’s time at work” in 2010 (CMA, 2010).

7 In 2010, the median age in Canada was 39.7 years, compared to 26.2 years in 1971. It is estimated that by 2051, about one in four Canadians will be 65 or over (HRSDC, 2011).

8 Approximately 41 percent of Canada’s specialist physicians (and 39 percent of all physicians) were aged 55 or older in 2011 (CMA, 2011).

9 A composite index consisting of “practicing physicians,” “professionally active physicians,” and “all physicians licensed to practice” (depending on the different ways countries report data) was used. For the purposes of ranking, data were extracted for 2008 (or the most recent year available). Data from 2009 were used for Italy as data from any previous year were unavailable. The OECD average for 34 countries was 3.0.

10 For the purposes of ranking, data were extracted for 2008 (or the most recent year available). Data from 2010 were used for New Zealand as data from any previous year were unavailable. The OECD average for 32 countries was 3.5.

11 Another reason for rationed operating room time availability might relate to the fact that global budget models are predominantly used to finance hospitals in Canada. Such models provide annual funding (in the form of a fixed budget) to hospitals in order to cover their operational costs, regardless of how many patients are admitted (Aas, 1995; Deber et al., 2008; Sutherland, 2011). Studies show that under-treatment or providing fewer services to patients in order to keep within budget is common under such

- payment schemes (Aas, 1995; Leonard et al., 2003)
- 12 In 2008, Canada had 9.2 nurses per thousand people (slightly above the OECD average of 8.35), ranking it 16th out of 34 (OECD 2011; calculations by author). For the purposes of ranking, a composite index consisting of “practicing nurses,” “professionally active nurses,” and “all nurses who are licensed to practice” was used. Data were extracted for 2008 (or the most recent year available). Data from 2009 were used for
 - 13 Data were compiled using ten editions of *Waiting Your Turn* published between 2001 and 2010. A total of over 25,000 surveys were included for analysis.
 - 14 Studies have demonstrated that when adjusted for age, Canada’s spending on health care ranks even higher than the figures presented above (see Esmail and Walker, 2008).
 - 15 Siciliani and Hurst (2003) also mention that waiting times are (anecdotally) reported to be low in Austria, Belgium, France, Germany, Japan, Luxembourg, Switzerland, and the United States.
 - 16 Canadians waited 96 percent longer in 2010 than they did in 1993 (Barua et al., 2010).
 - 17 Given the qualitative nature of the responses included in this analysis, the author acknowledges that only an *indicative*, rather than *definitive*, conclusion may be drawn.

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ISSN 1714-6720

Date of Issue: October 2011

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Editing, design, and production

Kristin McCahon

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