

Critical Issues Bulletins

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Date of Issue: October 2004

Printed and bound in Canada

Canadian Publications Mail Sales Product Agreement Number 40069269.

Return undeliverable Canadian addresses to
The Fraser Institute, Fourth Floor, 1770 Burrard Street,
Vancouver, British Columbia, Canada V6J 3G7.

ISSN 1480-3666

Editing and design: Kristin McCahon

Image for front cover: ©Rubberball Productions,
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Acknowledgments

This edition of *Waiting Your Turn: Hospital Waiting Lists in Canada* draws extensively on previous editions. We are pleased to acknowledge the important contributions of Steven Globerman, Lorna Hoye, Joanna Miyake, Cynthia Ramsay, Greg Wilson, and Martin Zelder in the completion of earlier versions of the survey and in building the base of knowledge that is incorporated into this publication.

Preface

This *Critical Issues Bulletin* is the Institute's fourteenth 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, they are still incomplete, meaning that there are no comprehensive measures other than those produced by The Fraser Institute by which to measure the length of waiting lists in Canada.

The contents of the survey have been 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 this interest in waiting lists continues and that Canadian policy makers begin to consider seriously the implications of queuing as they design alternatives to our present health care arrangements.

While this study and its widespread distribution 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 fourteenth annual waiting list survey found that Canada-wide waiting times for surgical and other therapeutic treatments changed very little in 2004. Total waiting time between referral from a general practitioner and treatment, averaged across all 12 specialties and 10 provinces surveyed, rose from 17.7 weeks in 2003 to 17.9 weeks in 2004. This small nationwide deterioration in access reflects waiting-time increases in 4 provinces, while concealing decreases in waiting time in Alberta, Manitoba, Quebec, New Brunswick, Nova Scotia, and Newfoundland.

Among the provinces, Manitoba achieved the shortest total wait in 2004, 14.8 weeks, with Ontario (15.5 weeks) losing the "best access" province status that it had held since 2000, and Alberta (17.8 weeks) next shortest. Saskatchewan exhibited the longest total wait, 33.3 weeks; the next longest waits were found in Prince Edward Island (27.4 weeks) and New Brunswick (20.9 weeks).

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

The rise in waiting time between 2003 and 2004 is the result of an increase in the first wait—the wait between visiting a general practitioner and attending a consultation with a specialist—while the wait between consultation with a specialist and actual treatment remained at the 2003 level. The waiting time between referral by a GP and consultation with a specialist grew from 8.3 weeks in 2003 to 8.4 weeks in 2004. The shortest waits for specialist consultations were in Manitoba (6.9 weeks), and Ontario and British Columbia (7.3 weeks). The longest waits for specialist consultations occurred in Prince Edward Island (11.8 weeks), Newfoundland (10.3 weeks), and New Brunswick (10.0 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—remained at 9.5 weeks in 2004. Decreases in Alberta, Manitoba, Quebec, Nova Scotia, and Newfoundland were matched by increases in the five other provinces. The shortest specialist-to-treatment waits were found in Manitoba (7.8 weeks), Ontario (8.2 weeks), and Alberta (8.3 weeks), while the longest such waits existed in Saskatchewan (24.5 weeks), Prince Edward Island (15.7 weeks), and British Columbia (11.6 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 (5.6 weeks), radiation oncology (7.8 weeks), and general surgery (9.9 weeks). Conversely, patients waited longest between a GP visit and orthopaedic surgery (37.9 weeks), plastic surgery (35.8 weeks), and ophthalmology treatment (28.7 weeks). There were striking increases between 2003 and 2004 in the wait times for plastic surgery (+7.2 weeks), orthopaedic surgery (+5.7 weeks), and neurosurgery (+2.6 weeks). These increases offset improvements for patients receiving treatment in elective cardiovascular surgery (-3.0 weeks), ophthalmology (-1.3 weeks), otolaryngology (-0.6 weeks), gynaecology (-0.5 weeks), medical oncology (-0.5 weeks), general surgery (-0.4 weeks), and radiation oncology (-0.3 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 (1.8 weeks), medical oncology (3.3 weeks), and cardiovascular surgery (4.2 weeks), while the longest waits are for plastic surgery (16.2 weeks),

neurosurgery (14.7 weeks), and orthopaedic surgery (13.8 weeks). For specialist-to-treatment waiting, patients wait the shortest intervals for urgent cardiovascular surgery (1.4 weeks), medical oncology (2.3 weeks), and general surgery (5.5 weeks), and wait longest for orthopaedic surgery (24.1 weeks), plastic surgery (19.6 weeks), and ophthalmology (15.3 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. 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 88 percent of the comparisons. Averaged across all specialties, Manitoba 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 43 and 59 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 2004. Patients also experienced significant waiting times for various diagnostic technologies across Can-

ada: computed tomography (CT), magnetic resonance imaging (MRI), and ultrasound scans. The median wait for a CT scan across Canada was 5.2 weeks. Nova Scotia had the shortest wait for computed tomography (4.0 weeks), while the longest wait occurred in Prince Edward Island (9.3 weeks). The median wait for an MRI across Canada was 12.6 weeks. Patients in Prince Edward Island experienced the shortest wait for an MRI (6.0 weeks), while Newfoundland residents waited longest (33.5 weeks). Finally, the median wait for ultrasound was 3.1 weeks across Canada. Both Alberta and Ontario displayed the shortest wait for ultrasound (2.0 weeks), while Newfoundland exhibited the longest ultrasound waiting time, 8.5 weeks.

Numbers of procedures for which people are waiting

The numbers of procedures for which people are waiting were also calculated. For the 2004 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 2004. Throughout Canada, the total number of procedures for which people are waiting in 2004 is 815,663, a decrease of 7 percent from the estimated 876,584 procedures in 2003.¹ The number of procedures waited for rose in Ontario, New Brunswick, Prince Edward Island, and Newfoundland. Assuming that each person was waiting for only one procedure, 2.58 percent of Canadians were waiting for treatment in 2004, which varied from a low of 1.99 percent in Alberta to a high of 6.93 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.

1 The 2004 figures are based on procedures counts classified by the recently introduced ICD-10/CCI data standard. Figures published in the 13th edition of *Waiting Your Turn* were based on the older ICD-9/CCP standard. For this reason, the numbers of procedures for which patients are waiting are not directly comparable with the previously published numbers because of a much more accurate counting of procedures that is possible under the new data standard. Previous estimates of procedures for which patients are waiting have been presented in this edition of *Waiting Your Turn*, but the changes between 2003 and 2004 should be interpreted with caution.

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 increased slightly in 2004—and its level is high, both historically and internationally. Compared to 1993, waiting time in 2004 is 92 percent 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 fourteenth edition, the authors can feel some satisfaction in the fact that the prime minister has given notice that the reduction of medical waiting lists and the shortening of waiting times is the nation's key health care priority. 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 waiting time information in their respective provinces. The significance of waiting lists to the health policy debate has been further emphasized by recent federal government insistence on accountability in the

form of annual report cards. 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 fourteenth 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 (Statistics 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 60 and 72 percent of these individuals indicated that they experienced “worry, stress, or anxiety,” and 45 to 55 percent reported experiencing pain while waiting for these specialized services. Between 17 and 29 percent of the individuals who had difficulties gaining access to 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

preoperative 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, Globerman (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 Globerman 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. 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 longer waiting times than do their urban counterparts (Ramsay, 1997) and residents of northern Ontario receive substantially lower travel reimbursement from the provincial gov-

ernment 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 companies in Ontario and British Columbia that facilitate diagnostic testing and treatment in the United States (Taube, 1999), and American medical centres advertise in Canadian newspapers. This year's survey of specialists (reported later in this study) found that 1.2 percent of patients received treatment in another country during 2004.

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 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-counted.

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

ties 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 and March 2004.

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 31 percent overall, the same rate as for 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 original 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.² 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 2003 and 2004. 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 survey 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 2003 and 2004.

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

2 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.

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 the Canadian Institute for Health Information's discharge abstract data from 2002-2003. This data is categorized using the recently-introduced ICD-10/CCI data standard, while previous years were based on the older and less precise ICD-9/CCP standard. Because the new data standard gives a much more accurate classification of procedures than the old data standard, the numbers of procedures for which patients are waiting in this edition of *Waiting Your Turn* are not directly comparable with the numbers from previously published editions of the survey. Previous estimates of procedures for which patients are waiting have been presented in this edition of *Waiting Your Turn*, but the changes between 2003 and 2004 should be interpreted with caution in this changeover year.

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 (see table 16) based on data submitted directly to CIHI by Salvation Army Grace Hospital, St. Boniface General Hospital, Victoria General Hospital, Seven Oaks General Hospital, Health Sciences Centre, and Winnipeg

Children's Hospital. Other facilities, which perform a significant number of surgeries in Manitoba, are excluded.³ New Brunswick data for 2002-03 were reported to CIHI using the ICD-9/CCP data standard, which does not easily compare with the new ICD-10/CCP format used by all other provinces. The authors made a pro-rated estimate of these 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. An example is ophthalmologic surgery for glaucoma, which is not categorized separately in the CIHI discharge abstract data. In these cases, we make no estimate of the number of patients waiting for these operations.

Because we are using discharge abstract data, our estimates of procedures waited for are more consistent with those produced by other sources. 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.

3 As an example, the Misericordia Eye Centre of Excellence performs over 90 percent of cataract surgeries in Manitoba (Bellan *et al.*, 2001).

Verification of current data with governments

In July 2004, we sent preliminary data across Canada to provincial ministries of health, and to provincial cancer and cardiac agencies. As of September 2004, we received substantive replies from provincial health ministries in Alberta, New Brunswick, Nova Scotia, Prince Edward Island, and Quebec, from cancer agencies in Nova Scotia and Newfoundland, from the Saskatchewan Surgical Care Network, and from the Cardiac Care Network of 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 data on their web sites providing waiting times and/or the numbers of patients waiting.

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 reports waiting times in a manner not comparable with the wait times measured in this survey. Specifically, the Alberta measurements report the waiting time within which 90 percent of non-emergent cases were treated, from the specialist's decision to treat, for the previous quarter. By comparison, The Fraser Institute reports prospective median waiting times for only elective procedures from the specialist's decision to treat the patient. There is a substantial difference between the measurement of prospective waiting times, the expected waiting time for the next patient, and retrospective waiting times (or the amount of time the patient actually waited for the surgery), since 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

Chart 1: Comparison of Numbers of Patients Waiting for Selected Procedures and Specialties in Alberta

Specialty/Procedure	Alberta Ministry of Health and Wellness Count	Fraser Institute Estimate
Plastic Surgery	1,889	1,758
Gynaecological Surgery	3,811	3,519
Eye Surgery (Ophthalmology)	2,643	4,623
Cataract Surgery	1,899	3,274
Ear, Nose, and Throat Surgery	2,595	1,787
General Surgery	4,880	4,850
Neurosurgery	363	512
Orthopaedic Surgery	7,746	10,083
Hip and Knee Replacement	4,186	7,038
Cardiac Surgery	467	350
Vascular Surgery	504	350
Thoracic Surgery	241	350
Coronary Artery Bypass Surgery	186	197
Urological Surgery	1,727	2,369

Sources: Alberta Ministry of Health and Wellness web site, and The Fraser Institute's hospital waiting list survey.

that occurred resulting from 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.). In addition, there is a substantial difference between the median measurement of only elective surgeries, and a measurement of the time within which 90 percent of all non-emergent patients were served. Finally, The Fraser Institute's survey captures waiting time information for the entire province of Alberta, while the Ministry's website only publishes information for those facilities that provide a minimum of 3 months of data.

Though the waiting times themselves cannot be directly compared, it is possible to compare the number of patients waiting published on the Ministry's website with those estimated by The Fraser Institute (chart 1). Despite the substantial differences in methodology mentioned above, it appears that in most cases The Fraser Institute's estimates of patients waiting in Alberta either closely approximate or underesti-

Chart 2: Waiting Times in British Columbia—Time to Exhaust List of Patients Waiting Reported by Ministry

Specialty/Procedure	Median Wait (Weeks)	Patients Waiting	Procedures	Procedures/Week	Expected Wait ¹
Plastic Surgery	5.4	4,918	609	142.1	34.6
Gynaecology	4.1	5,823	1,482	345.8	16.8
Ophthalmology	10.1	15,821	1,925	449.2	35.2
Cataract Surgery	11.4	14,308	1,584	369.6	38.7
Cornea Transplant	23.6	626	48	11.2	55.9
Otolaryngology	7.0	5,160	768	179.2	28.8
General Surgery	3.7	12,958	2,706	631.4	20.5
Neurosurgery	3.3	1,274	313	73.0	17.4
Orthopaedic Surgery	8.4	18,871	1,760	410.7	46.0
Hip Replacement Surgery	22.0	2,842	185	43.2	65.8
Knee Replacement Surgery	30.3	4,843	219	51.1	94.8
Cardiac Surgery	14.9	409	91	21.2	19.3
Vascular Surgery	3.0	1,241	340	79.3	15.6
Urology	3.4	5,954	1,337	312.0	19.1
Radiation Oncology	0.9	237	9,509	199.3	1.2

Waits as at April 30, 2004 (April 22, 2004 for Radiation Oncology). Procedures column counts the procedures performed between April 1, 2004 and April 30, 2004 except for Radiation Oncology which measured the procedures performed between April 1, 2003 and February 29, 2004.

¹Number of weeks to exhaust the list of patients waiting (patients waiting/procedures per week).

Source: British Columbia Ministry of Health Services Wait List web site.

mate the actual experience in Alberta. Only in the cases of Ophthalmology, Orthopaedic Surgery, and Urology are the Institute's estimates substantially greater than those published on the Alberta Ministry of Health and Wellness' website.

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 scheduled and the time it is actually carried out. Not only does this definition omit waiting time between GP and specialist (which the Institute's survey includes in the total), but it also understates the patient's actual waiting time between seeing a specialist and receiving treatment. Nevertheless, the ministry suggests that the degree of understatement is small: "We believe that in most procedures surgeons forward... booking forms without delay once a decision to perform the procedure is

taken, and that hospitals receive them within a day or two" (Kelly, 1999). However, because most hospitals only book a few months ahead, this method of measuring waiting lists undoubtedly omits a substantial fraction of patients with waits beyond the booking period (see Ramsay, 1998).

The BC Ministry of Health's web site lists surgical waiting times for the province. These wait times appear very low, given the number of people reported waiting for treatment and the reported number of procedures. Charts 2 and 3 summarize this.

For example, the ministry reports that 4,918 patients were waiting for plastic surgery on April 30, 2004 and that there were 609 plastic surgeries performed that month (a rate of 142 procedures per week). Assuming that all patients on the list end up having the surgery (most, but not all, will), and that they have one procedure each, it would take 34.6 weeks (the "expected" wait) to empty the plastic surgery waiting list of those patients waiting at April 30. The government

Chart 3: Comparison of Reported Waiting Times in British Columbia, Specialist to Treatment

Specialty/ Procedure	BC Health Median Wait ¹	BC Health Expected Wait ²	Fraser Institute Median Wait ³
Plastic Surgery	5.4	34.6	22.8
Gynaecology	4.1	16.8	8.6
Ophthalmology	10.1	35.2	12.0
Cataract Surgery	11.4	38.7	13.3
Cornea Transplant	23.6	55.9	48.5
Otolaryngology	7.0	28.8	16.7
General Surgery	3.7	20.5	7.6
Neurosurgery	3.3	17.4	8.3
Orthopaedic Surgery	8.4	46.0	32.2
Hip Replacement Surgery	22.0	65.8	52.0
Knee Replacement Surgery	30.3	94.8	52.0
Cardiac Surgery	14.9	19.3	13.3
Vascular Surgery	3.0	15.6	13.3
Urology	3.4	19.1	6.9
Radiation Oncology	0.9	1.2	1.5

¹Retrospective median wait at April 30, 2004.

²Number of weeks to exhaust the list of patients waiting (patients waiting/procedures per week).

³Prospective median wait, national hospital waiting list survey, 2004.

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

reported a wait of only 5.4 weeks. This simply cannot be correct.

Either there are fewer people waiting, a lot more surgeries being completed, or the government's number of a 5.4-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 performed per week.

At April 30, 2004, the government's reported median wait averaged 31 percent of the "expected" wait, ranging from 16 percent (for plastic surgery) to 77 percent (for cardiac surgery). The Institute median wait data, meanwhile, averages 62 percent of the "expected" wait.

The comparison between government median wait and "expected" wait data suggests that as many as half of patients give up the wait or go elsewhere for treatment—or it suggests that the government's numbers are not consistent.

It is interesting to note, however, that the number of people waiting and the number of procedures performed is broadly consistent with The Fraser Institute's survey estimates. While it was not their intention to do so, the British Columbia government has actually provided independent verification of The Fraser Institute waiting list survey.

Saskatchewan

The Saskatchewan Surgical Care Network (SSCN) launched a wait list web site in January 2003 (Glynn, 2003) providing measures of waiting times in Regina and Saskatoon.⁴ 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 website 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

4 *Waiting Your Turn* measures waiting times throughout the province of Saskatchewan while Saskatchewan Health measures waiting times only for those procedures performed in Saskatoon and Regina. The measurement of waiting times outside these major centres, where 70 percent of procedures are performed (Glynn, 2003), means that The Fraser Institute's estimates of waiting times will capture information on 30 percent of the procedures in the province that have been missed in Saskatchewan's own measurement.

Chart 4: Comparison between Saskatchewan Surgical Care Network Wait List Measures and Waiting Your Turn 2004

Specialty/Procedure	SSCN Wait	SSCN Elective Wait ¹	Fraser Institute Median
Plastic Surgery	25.0	35.1	59.7
Gynaecology	21.7	30.8	13.6
Tubal Ligation	27.2	33.7	12.0
Hysterectomy	26.2	31.3	24.0
Ophthalmology	30.1	33.3	30.5
Cataract Surgery	32.3	34.0	36.0
Operations on Vitreous	5.4	14.5	2.5
Otolaryngology	26.6	38.4	55.8
Myringotomy	8.4	14.5	5.0
Tonsillectomy	50.5	54.2	90.0
General Surgery	15.3	25.8	13.4
Hernia Repair	21.5	27.9	26.0
Breast Biopsy	4.4	14.5	2.8
Mastectomy	7.8	22.5	2.5
Neurosurgery	17.8	30.2	12.5
Disc Surgery/Laminectomy	20.0	29.5	24.0
Orthopaedic Surgery	30.8	35.6	75.2
Hip Replacement	37.9	39.4	104.0
Knee Replacement	47.4	47.9	104.0
Cardiovascular Surgery	9.0	20.6	2.0 (Urgent)
Bypass Surgery	8.5	17.5	2.0 (Urgent)
Cardiovascular Surgery	9.0	20.6	12.4 (Elective)
Bypass Surgery	8.5	17.5	16.0 (Elective)
Urology	15.0	23.0	13.3
Prostatectomy	19.3	23.1	4.0/70.0
Bladder Resection	7.0	14.5	4.0
Cystoscopy	11.4	18.9	2.0

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: 42% of patients in Saskatchewan waited less than 3 weeks for Neurosurgery, 35% waited 3 weeks to 6 months, 13% waited 7 to 12 months, and 5% waited more than 18 months. Taking the midpoints of each time frame to be 1.5, 14.5, 41.2, 67.2, and 82 weeks respectively gives an average waiting time of 17.8 weeks.

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. In an attempt to eliminate the measure of urgent procedures, the shortest time frame is removed to allow better comparability with the waiting times presented in *Waiting Your Turn*.

Sources: Saskatchewan Surgical Care Network website; calculations by authors; and The Fraser Institute's hospital waiting list survey.

booking. A telephone survey of Saskatchewan physicians 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, which 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 website measures waiting times for all non-emergent surgeries (i.e., all 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 website but not in those measured by The Fraser Institute.

The resulting conclusion is that the numbers available on the SSCN website are not comparable to those measured in *Waiting Your Turn* and may not measure what the government of Saskatchewan thinks they measure. Further work by the department is required—and is in fact in progress—to create waiting list measures that comprehensively and accurately measure the sort of patient experience which it is the intent of *Waiting Your Turn* to capture.

Despite these differences in methodology, it appears that The Fraser Institute's estimates of waiting times in Saskatchewan either closely approximate or underestimate the actual experience in that province in

Chart 5: Comparison of Procedures for which Patients were Waiting between Saskatchewan Surgical Care Network Wait List Measures and Waiting Your Turn 2004

Specialty	SSCN Procedures	SSCN Procedures Annual	SSCN Wait Time	SSCN Estimate ¹	SSCN Estimate of All SK	FI Estimate
Plastic Surgery	1,278	2,556	25.0	1,230	1,757	2,200
Gynaecology	3,000	6,000	21.7	2,503	3,576	2,047
Ophthalmology	4,745	9,490	30.1	5,488	7,840	9,420
Otolaryngology	1,839	3,678	26.6	1,878	2,683	4,963
General Surgery	3,774	7,548	15.3	2,226	3,181	5,116
Neurosurgery	632	1,264	17.8	434	620	335
Orthopaedic Surgery	3,660	7,320	30.8	4,341	6,202	13,203
Cardiovascular Surgery	732	1,464	9.0	253	361	79
Urology	1,226	2,452	15.0	709	1,013	3,574
Overall Wait Time	—	—	10.1	24,024	34,320	68,984

Note: SSCN procedure counts between October '03 and March '04. Overall procedure count for January 1, 2004 to March 31, 2004.

¹Estimates of the procedures for which patients are waiting using SSCN data are developed using the same methodology that The Fraser Institute employs to develop its own estimate, which is presented in the last column.

²SSCN counts only those cases performed in Regina and Saskatoon; these people comprise approximately 70 percent of all surgical cases in Saskatchewan (Glynn, 2003). To determine the total number of people waiting in the province, we added the remaining 30 percent.

Sources: Saskatchewan Surgical Care Network web site, calculations by authors; and The Fraser Institute's hospital waiting list survey.

most cases (chart 4). Only in the cases of Plastic Surgery, Orthopaedic Surgery, and Otolaryngology are the Institute's estimates notably longer than the wait times reported on the SSCN's web site.

Though the process for estimating the number of procedures for which patients are waiting was revised last year, resulting in estimates that more closely approximate the counts produced by SSCN (chart 5), there are still substantial differences in some categories. The high estimates in Saskatchewan stem from two sources: first, the number of procedures done in Saskatchewan is abnormally high when compared to other Canadian provinces. Second, the wait times in Saskatchewan are also abnormally high when compared to the rest of Canada. Thus, the methodology used in *Waiting Your Turn* to estimate the number of procedures for which people are waiting (described above) generates abnormally (compared to other provinces) high numbers of people waiting in Saskatchewan.

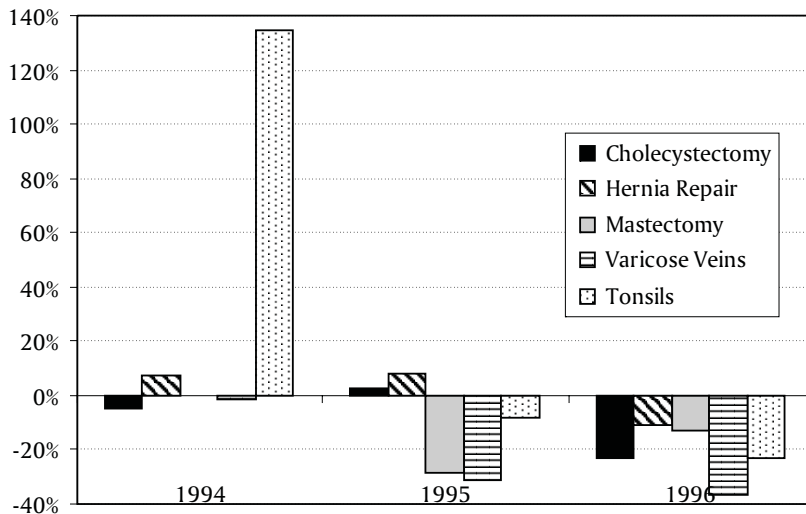
As a result, this year's numbers should be interpreted with caution, especially for Saskatchewan. Although this cautionary note applies to all estimates of the numbers of procedures for which patients are waiting, there do not appear to be significant systematic differ-

ences 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 other provincial ministries.

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 18.0 weeks for orthopaedic surgery, 4.2 weeks for elective cardiovascular surgery, and 17.1 weeks for ophthalmology procedures in 2004.

Chart 6: 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 hospital waiting list surveys.

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 non-small-cell lung cancer were 30.3 days, 27.2 days, and 27.3 days, respectively. In Ontario in 2004, the wait for radiotherapy was approximately 42 days for cancer of the larynx, 30 days for cancer of the cervix, and 42 days for lung cancer (see tables 3 and 5k). However, the 2004 estimate that the median wait for prostate cancer treatment was 70 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 2004, the wait to see an orthopaedic specialist was 12.5 weeks (see table 3) and the wait to receive hip or knee surgery was 24.0 weeks (see table 5g).

Examination of waiting times for particular cardiovascular treatments in 1990 by Collins-Nakai *et al.* (1992)

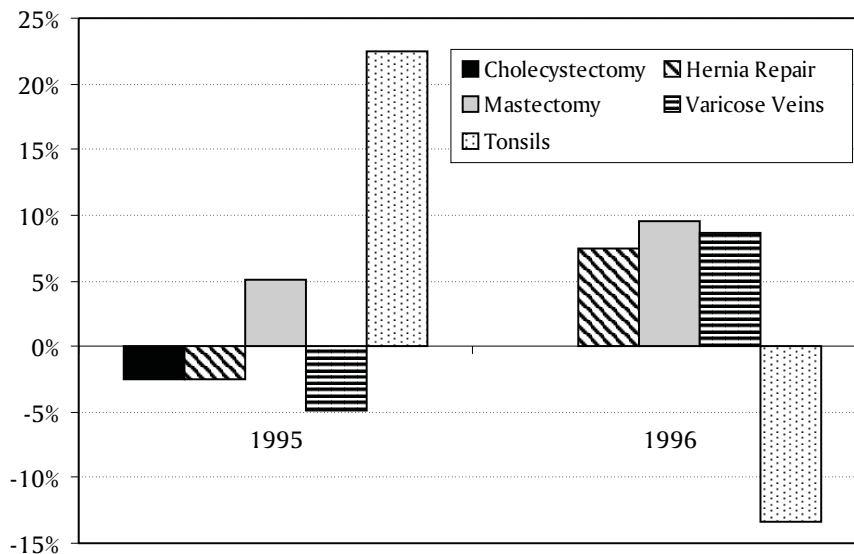
focused on three important procedures. They estimated median Canadian waiting times of 11 weeks for angioplasty and 5.5 months for cardiac bypass surgery. In comparison, 2004 median waiting times for "angiography/angioplasty" ranged from 4.0 weeks in Ontario to 24.0 weeks in New Brunswick (see table 5j), and for elective cardiac bypass ranged from 4.0 weeks in Ontario and Quebec to 62.0 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 2004 data indicated that the provincial waiting time for elective bypass surgery (between specialist consultation and treatment) ranged from 4.0 weeks in Ontario and Quebec to 62.0 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 2004 Ontario survey data reveal waiting times for emergent, urgent, and elective bypass surgery of 0, 7, and 28 days respectively (see table 5h).

Five 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

Chart 7: Fluctuation in Manitoba Centre for Health Policy and Evaluation Waiting Times, 1995 and 1996



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

equal to or shorter than those measured by MCHPE (chart 6).

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 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 7 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.

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 significant 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 more⁵ 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, 24 independent waiting time estimates exist for comparison with recent Institute figures. In 19 of 24 cases, the Institute figures lie below the comparison values. In only four instances does the Institute value exceed the comparison value, and in one case 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 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

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

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 2004, an average of 2.4 percent of cardiac patients inquired about receiving treatment in another province, while 2.0 percent asked about treatment in another country. From these inquiries, 1.4 percent of all patients received treatment in another province and 0.9 percent received treatment in another country (Fraser Institute, national hospital waiting list survey, 2004).

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 provin-

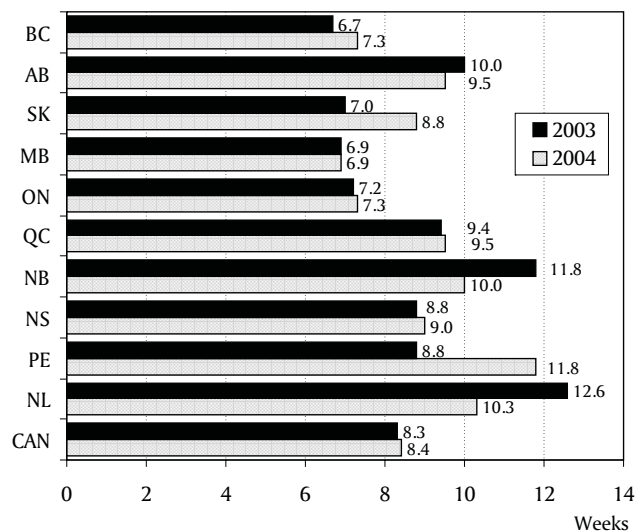
cial cardiac agencies. These data are noted in the tables.

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 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 2004 was 3.1 weeks (Alberta and New Brunswick) (see tables 4 and 5h). Finally, the Ontario panel suggests that elective surgeries be performed within a period of 24 weeks. Newfoundland currently falls outside of this time frame (see tables 4 and 5h).

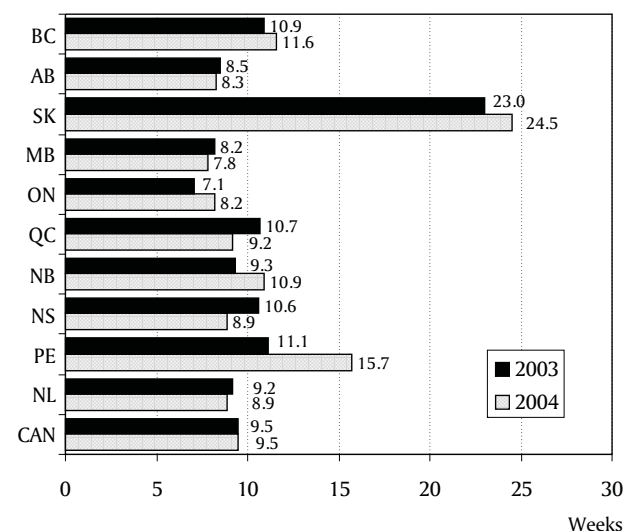
Prior to 1998, this Ontario panel's waiting-time estimates were used as the measure of the clinically reasonable wait for patients requiring cardiovascular surgery. Since 1998, cardiovascular surgeons were asked to indicate their impression of the clinically reasonable length of time for their patients 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 0.9 weeks for surgery (instead of 6 weeks), and that patients requiring elective cardiovascular surgery should only wait 4.9 weeks (instead of 24 weeks; see table 8).

Chart 8: Waiting By Province in 2003 and 2004: Weeks Waited from Referral by GP to Appointment with Specialist



Source: The Fraser Institute, annual waiting list survey, 2004.

Chart 9: Waiting by Province in 2003 and 2004: Weeks Waited from Appointment with Specialist to Treatment



Source: The Fraser Institute, annual waiting list survey, 2004.

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 2004 provide details, by province, of total waiting and of each segment.

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, 8.4 weeks in 2004, has increased by 127 percent since 1993, when it was 3.7 weeks (see graphs 1 and 2). The weighted medians, depicted in chart 8 and graph 1, reveal that Manitoba has the shortest waits in the country for appointments with specialists (6.9 weeks), while Prince Edward Island has the longest (11.8 weeks). The waiting time

to see a specialist has increased in 6 provinces since 2003, and has fallen in Alberta, New Brunswick, and Newfoundland. 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, Quebec, New Brunswick, Nova Scotia, or Newfoundland; to see a gynaecologist in Saskatchewan; to see an ophthalmologist in Saskatchewan, 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, Saskatchewan, Ontario, New Brunswick, or Newfoundland; to see an orthopaedic surgeon in British Columbia, Alberta, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia, or Newfoundland; to see a urologist in Alberta, Manitoba, New Brunswick, Nova Scotia, Prince Edward Island, or Newfoundland; and to see an internal medicine specialist in Prince Edward Island.

Waiting time between specialist consultation and treatment

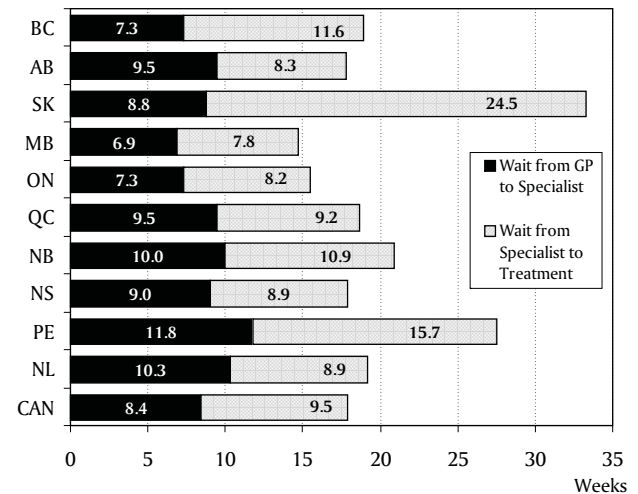
Tables 5a through 5l contain data on the time waited between specialist consultation and treatment for

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 9 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 did not change from the 2003 level (9.5 weeks). This portion of waiting has increased by 70 percent since 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 2004 weighted medians indicates that the longest median wait for surgery after visiting a specialist occurs in Saskatchewan (24.5 weeks) and the shortest is in Manitoba (7.8 weeks). Chart 9 illustrates the median waits for treatment by province. Among the specialties, the longest Canada-wide waits are for orthopaedic surgery (24.1 weeks), plastic surgery (19.6 weeks), and ophthalmology (15.3 weeks), while the shortest waits exist for urgent cardiovascular surgery (1.4 weeks), medical oncology (2.3 weeks), and general surgery (5.5 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. Ontario performs the highest proportion of surgeries within 13 weeks (79.1 percent), while Newfoundland performs the highest proportion within 8 weeks (64.5 percent). Waits of 26 weeks or more are least frequent in Alberta (8.6 percent), and most frequent in Saskatchewan (34.4 percent).

Table 6 compares the 2003 and 2004 waiting times for treatment. This year's study indicates an overall increase in the waiting time between consultation with a specialist and treatment in 5 provinces, with decreases in Alberta (2%), Manitoba (4%), Quebec (14%), Nova Scotia (16%), and Newfoundland (2%) (table 6 and chart 9). At the same time, between 2003 and 2004, the median wait increased by 7 percent in British Columbia, 7 percent in Saskatchewan, 16 percent in Ontario, 17 percent in New Brunswick, and 41 percent in Prince Edward Island.

Chart 10: Median Wait by Province in 2004: Weeks Waited from Referral by GP to Treatment



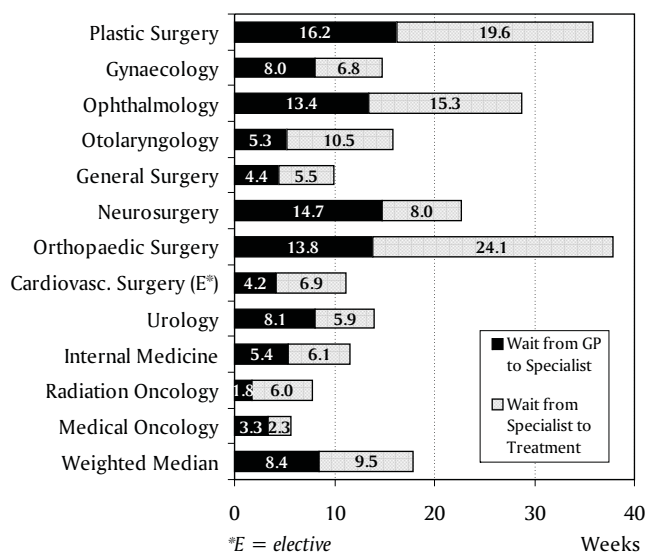
Note: Totals may not match sum of subtotals due to rounding.
Source: The Fraser Institute, annual waiting list survey, 2004.

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 10 present these total wait times for each province in 2004. For Canada as a whole, total waiting time rose to 17.9 weeks in 2004 from its previous value of 17.7 weeks in 2003. Among the provinces, total waiting time fell in 6 (Alberta, Manitoba, Quebec, New Brunswick, Nova Scotia, and Newfoundland) between 2003 and 2004, but rose in the other 4. The shortest total waiting times in 2004 were recorded in Manitoba (14.8 weeks), Ontario (15.5 weeks), and Alberta (17.8 weeks). The longest total waits were in Saskatchewan (33.3 weeks), Prince Edward Island (27.4 weeks), and New Brunswick (20.9 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

Chart 11: Median Wait by Specialty in 2004: Weeks Waited from Referral by GP to Treatment



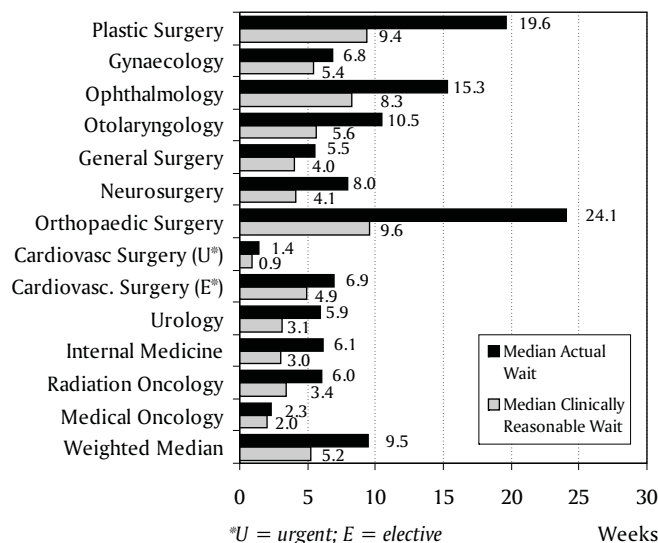
Note: Totals may not match sum of subtotals due to rounding.
Source: The Fraser Institute, annual waiting list survey, 2004.

(table 2 and chart 11) are longer than 6 months: 37.9 weeks for orthopaedic surgery, 35.8 weeks for plastic surgery, and 28.7 weeks for ophthalmology. The shortest wait in Canada is for cancer patients being treated with chemotherapy. These patients wait approximately 5.6 weeks to receive treatment.

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-eight 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 22.8 weeks. A clinically reasonable length of time to wait, according to specialists in British Columbia, is 9.9 weeks. In Quebec, the

Chart 12: Median Actual Wait Versus Median Clinically Reasonable Wait by Specialty for Canada: Weeks Waited from Appointment with Specialist to Treatment in 2004



Source: The Fraser Institute, annual waiting list survey, 2004.

actual time to wait for an ophthalmological procedure is 15.3 weeks, whereas a wait of 9.6 weeks is considered to be clinically reasonable. Table 10 summarizes the differences between the median reasonable and median actual wait for specialties.

Chart 12 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 14.5 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 9,992 gynaecology procedures for which people are waiting, while there are only 3,519 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: 112 procedures per 100,000 people there, versus 82 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 2003 with those in 2004. It should be noted that the procedure counts on which these estimates are based are now classified using the ICD-10/CCI data standard, which is significantly different from the previous ICD-9/CCP data standard. Thus,

these changes should be interpreted with caution in this changeover year. In six provinces, the estimated number of procedures for which people are waiting decreased between 2003 and 2004. The estimated number of procedures for which people are waiting in Canada as a whole also fell, from 876,584 in 2003 to 815,663 in 2004, a 7 percent decrease. As a percentage of the population, 2.58 percent of Canadians were waiting for treatment in 2004,⁶ varying from a low of 1.99 percent in Alberta to a high of 6.93 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

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

Chart 13: Canadian Doctors, Medical Technology, and Health Spending Relative to the Universal Access Countries of the OECD¹, Age-Adjusted², 2001

Comparison	Canadian Value	OECD Average	Canadian Rank	Number of Countries
Doctors per 1,000 Population	2.3	2.5	16	23
CT Scanners per Million Population	10.5	17.0	17	23
Radiation Equipment per Million Population	7.8	7.0	8	22
MRI Scanners per Million Population	3.9	6.3	15	24
National Health Expenditure as a Percent of GDP	10.8	8.3	1	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, 2004).

Source: Esmail and Walker, 2004.

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 which Canadian health care is provided. Canadian health care is an enterprise highly dominated by government. Indeed, in 2003, the fraction of total Canadian health spending attributable to governments was 69.8 percent (OECD, 2004). 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 13 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 tied with Iceland for the title of highest spender on health care (as a percentage of GDP) amongst the universal-access, public-health-care-system countries in the OECD in 2001 after accounting for the age of the Canadian population (Esmail and Walker, 2004), the age-adjusted availability of medical technology (per million people) in Canada typically ranks in the bottom third of OECD nations. Specifically, Canada exhibits low availability of computed tomography (CT) scanners, lithotripters (which break up kidney stones), and magnetic resonance imagers (MRIs), with only radiation equipment in relative abundance. 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 14 displays the median number of weeks patients must wait for access to a CT, MRI, or ultrasound scanner. The median waits for all three diagnostic scans were shorter in 2004 than in 2003. The median wait for a CT scan across Canada was 5.2 weeks. The shortest wait for computed tomography was in Nova Scotia (4.0 weeks), while the longest wait occurred in Prince Edward Island (9.3 weeks). The median wait for an MRI across Canada was 12.6 weeks. Prince Edward Island patients waited the least amount of time for an MRI (6.0 weeks), while Newfoundland residents waited longest (33.5 weeks). Finally, the median wait for ultrasound was 3.1 weeks across Canada. Alberta and Ontario displayed

Chart 14: Waiting for Technology—Weeks Waited to Receive Selected Diagnostic Tests in 2001-02, 2003, and 2004.

Province	CT-Scan			MRI			Ultrasound		
	2004	2003	2001-02	2004	2003	2001-02	2004	2003	2001-02
British Columbia	5.5	6.0	6.0	12.0	12.0	18.0	2.5	2.5	2.5
Alberta	6.0 ¹	6.0	6.0	12.0 ²	12.0	8.0	2.0	2.8	3.0
Saskatchewan	8.0	6.8	8.0	25.0	20.0	14.0	2.8	2.0	2.0
Manitoba	6.0 ³	7.0	6.0	11.0 ⁴	10.0	9.0	8.0 ⁵	8.0	10.0
Ontario	5.0	5.0	5.0	12.0	10.0	11.0	2.0	2.0	2.0
Quebec	5.0	6.0	4.5	12.0	15.0	13.5	4.0	6.0	4.0
New Brunswick	4.5	4.0	4.0	7.0	8.0	5.0	4.0	4.0	4.0
Nova Scotia	4.0	4.0	4.0	12.0	24.0	16.0	3.5	3.0	4.0
P.E.I.	9.3	8.0	6.0	6.0	12.0	12.0	8.0	6.0	9.0
Newfoundland	4.3	4.0	8.0	33.5	24.0	20.0	8.5	6.0	7.5
Canada	5.2	5.5	5.2	12.6	12.7	12.4	3.1	3.6	3.2

¹Alberta Health and Wellness web site reports that in 18 facilities across the province, 90% of patients waiting for non-emergent CT scans received the service within a range of 3 to 19 weeks for the quarter ending June 30, 2004. 14,314 Albertans were waiting for a CT scan at these 18 facilities at June 30.

²Alberta Health and Wellness web site reports that in 12 facilities across the province, 90% of patients waiting for non-emergent MRI scans received the service within a range of 5 to 36 weeks for the quarter ending June 30, 2004. 20,753 Albertans were waiting for an MRI scan at these 12 facilities at June 30.

³Manitoba Health web site reports an average waiting time of 9 weeks for elective CT scans for the month of June 2004.

⁴Manitoba Health web site reports an average waiting time of 15 weeks for elective MRI procedures for the month of June 2004.

⁵Manitoba Health web site reports an average waiting time of 12 weeks for elective ultrasound procedures for the month of June 2004.

the shortest wait (2.0 weeks) while Newfoundlanders, at 8.5 weeks, waited the longest for ultrasound.

Conclusion

The 2004 *Waiting Your Turn* survey indicates that waiting times for medical treatment in Canada continue to grow. 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 4.7 percent of radiation oncology patients requesting a

delay of treatment, to a high of 10.0 percent of general surgery 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 (Fraser Institute, national hospital waiting list survey, 2004).

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.

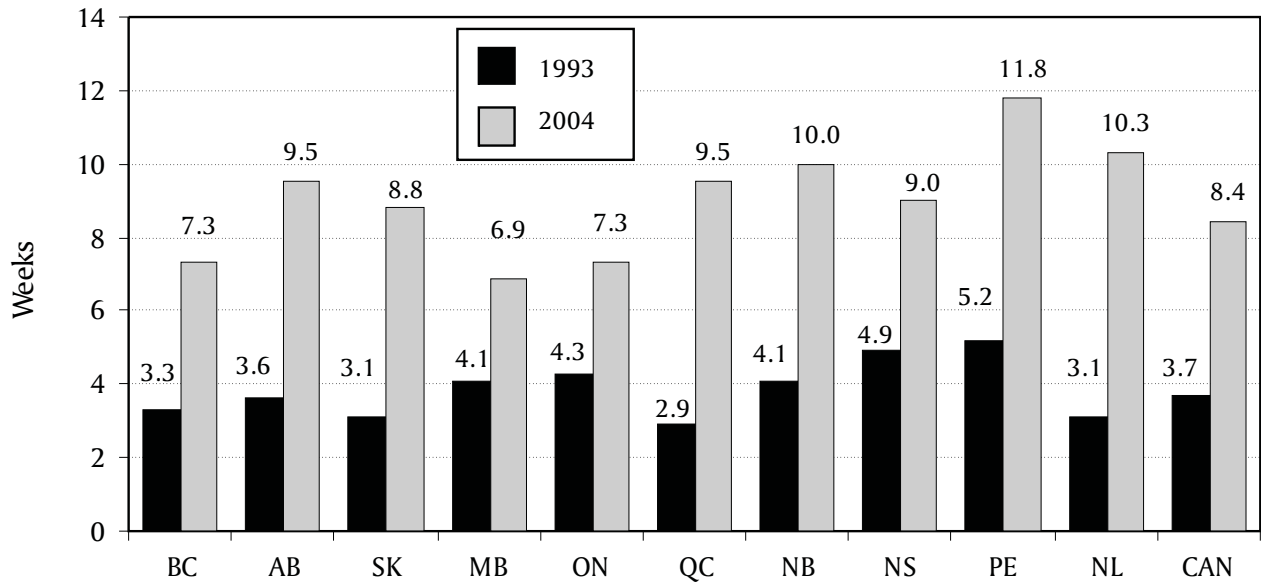
Selected Graphs

Graphs 1–6: Median Actual Waiting Times, 1993 and 2004

Graphs 7–8: Median Reasonable Waiting Times, 1994 and 2004

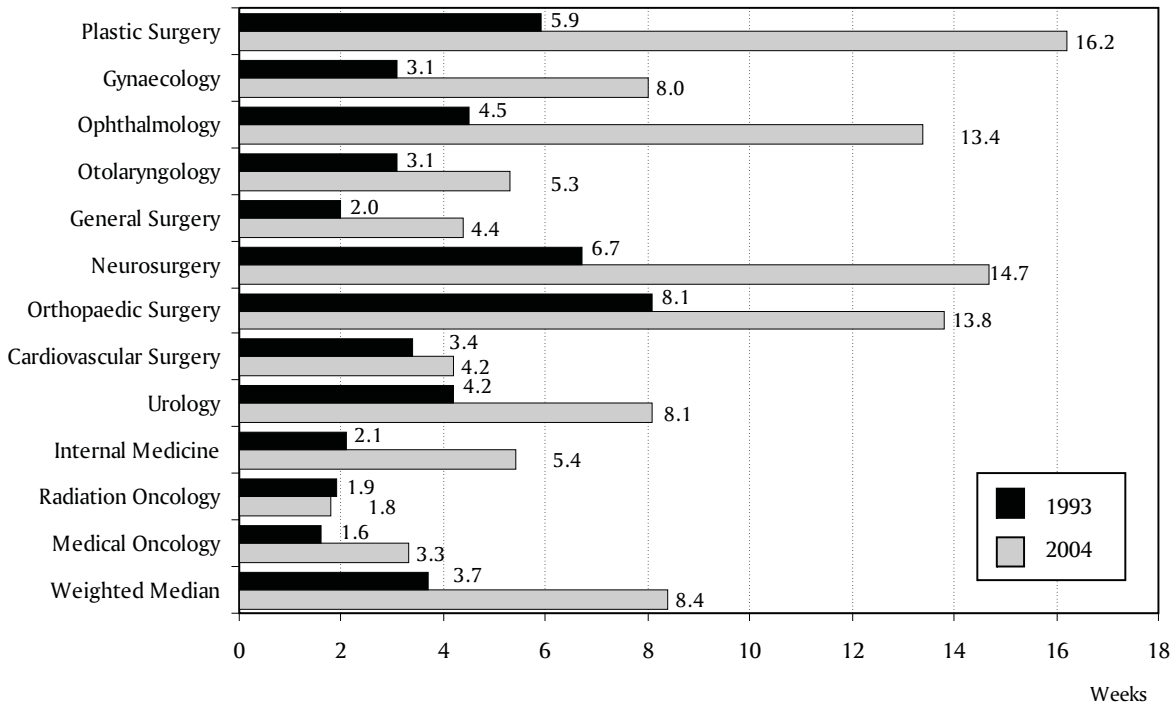
Graphs 9–19: Actual versus Reasonable Waiting Times, 1994 through 2004, by Province

Graph 1: Median Wait Between Referral by GP and Appointment with Specialist, by Province, 1993 and 2004



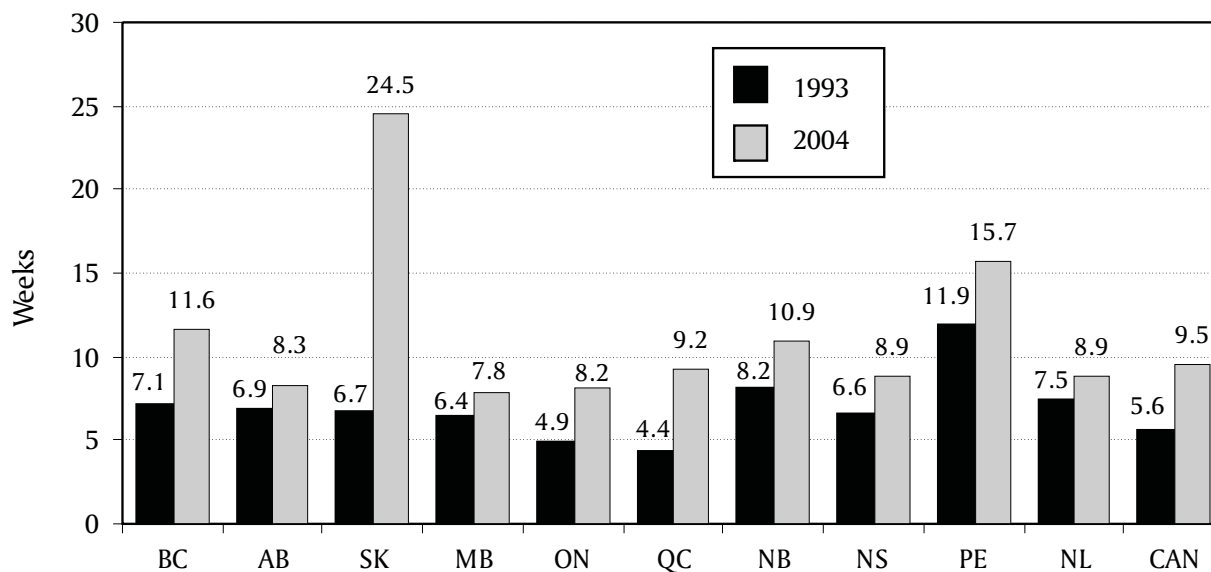
Source: The Fraser Institute, annual waiting list survey, 2004; and Ramsay and Walker, 1997.

Graph 2: Median Wait between Referral by GP and Appointment with Specialist, by Specialty, 1993 and 2004



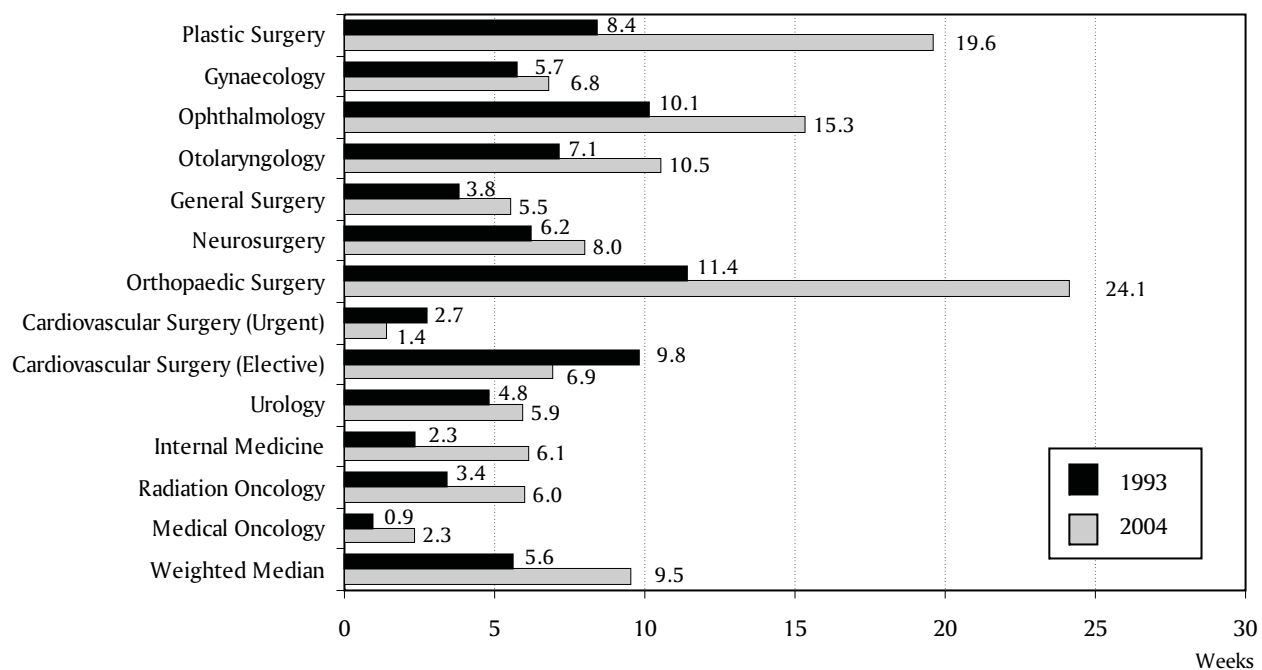
Source: The Fraser Institute, annual waiting list survey, 2004; and Ramsay and Walker, 1997.

Graph 3: Median Wait between Appointment with Specialist and Treatment, by Province, 1993 and 2004



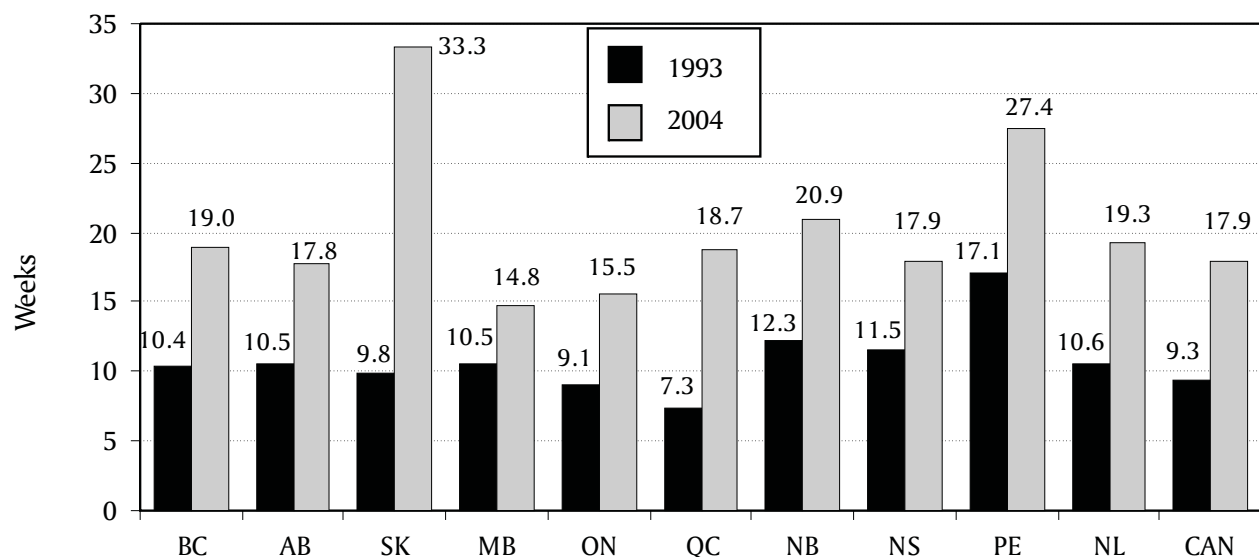
Source: The Fraser Institute, annual waiting list survey, 2004; and Ramsay and Walker, 1997.

Graph 4: Median Wait between Appointment with Specialist and Treatment, by Specialty, 1993 and 2004



Source: The Fraser Institute, annual waiting list survey, 2004; and Ramsay and Walker, 1997.

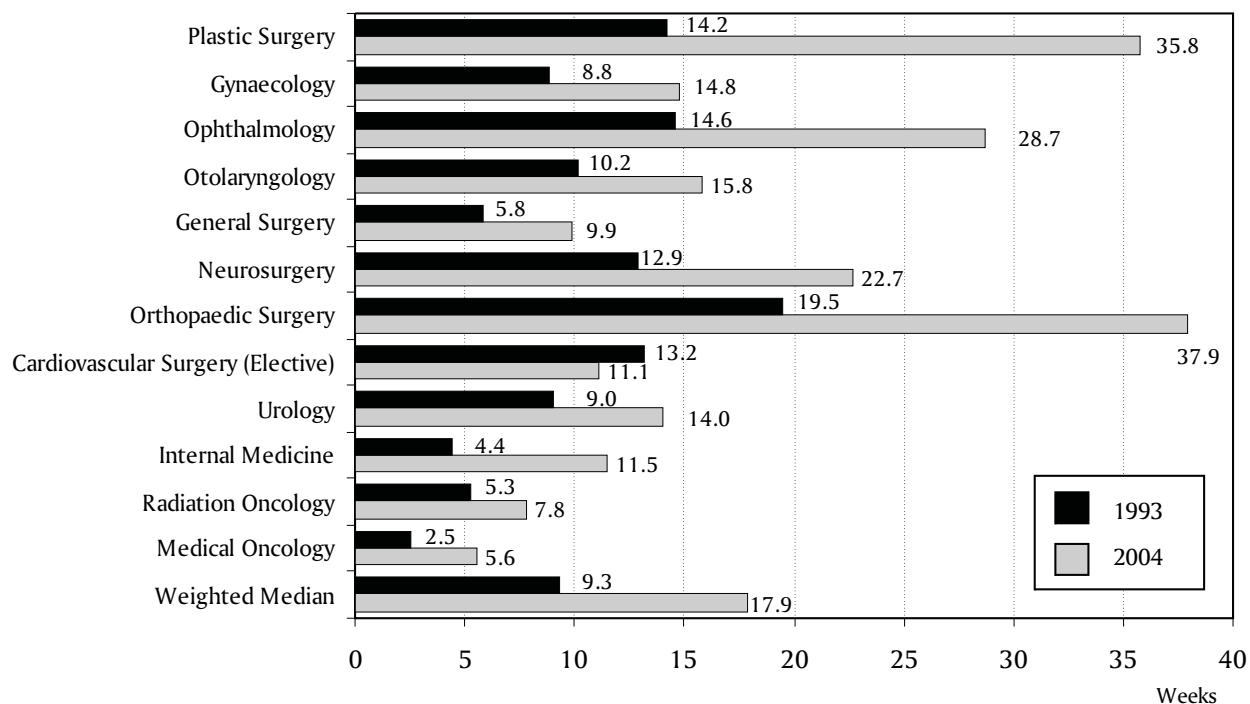
Graph 5: Median Wait between Referral by GP and Treatment, by Province, 1993 and 2004



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

Source: The Fraser Institute, annual waiting list survey, 2004; and Ramsay and Walker, 1997.

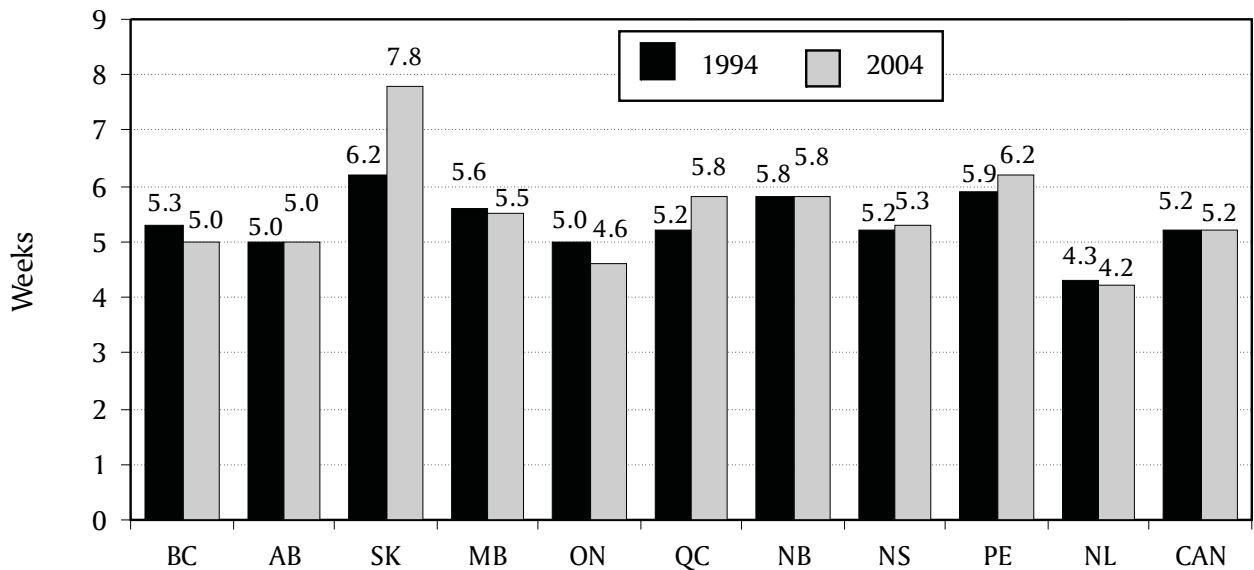
Graph 6: Median Wait between Referral by GP and Treatment, by Specialty, 1993 and 2004



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

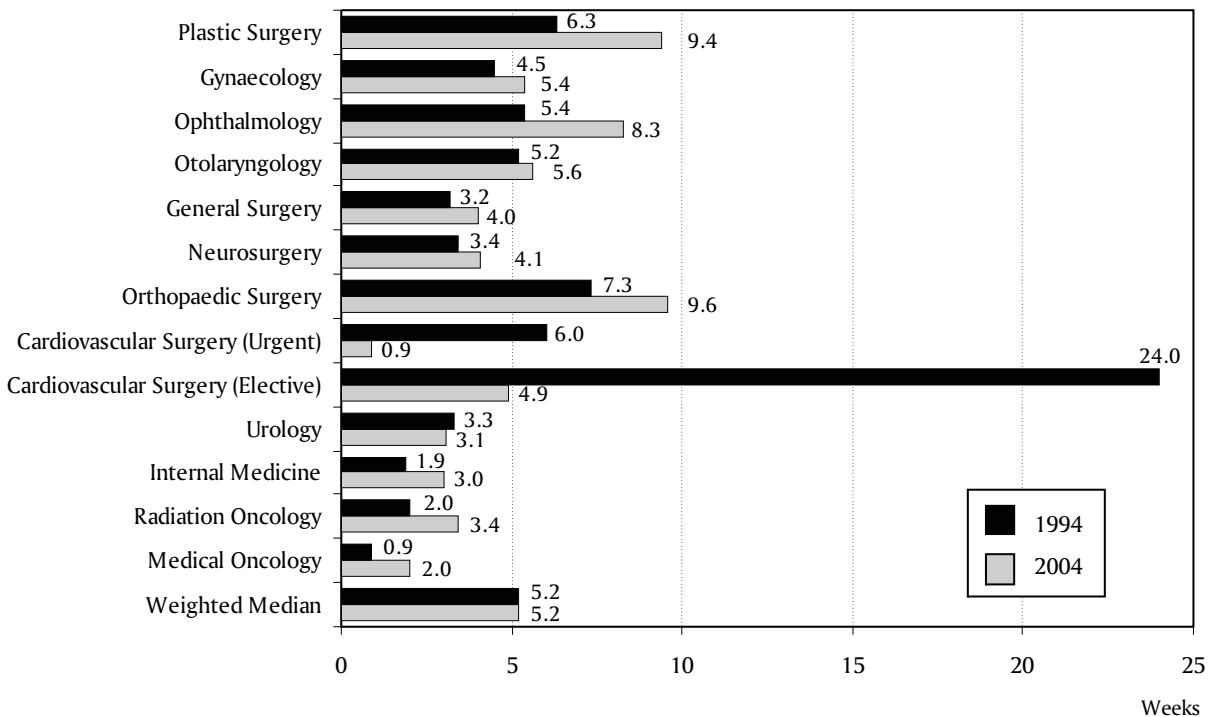
Source: The Fraser Institute, annual waiting list survey, 2004; and Ramsay and Walker, 1997.

Graph 7: Median Reasonable Wait between Appointment with Specialist and Treatment, by Province, 1994 and 2004



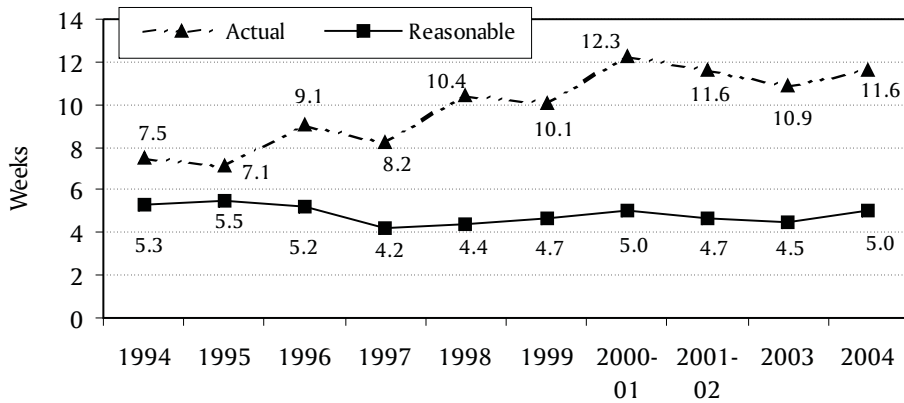
Source: The Fraser Institute, annual waiting list survey, 2004; and Ramsay and Walker, 1997.

Graph 8: Median Reasonable Wait between Appointment with Specialist and Treatment, by Specialty, 1994 and 2004



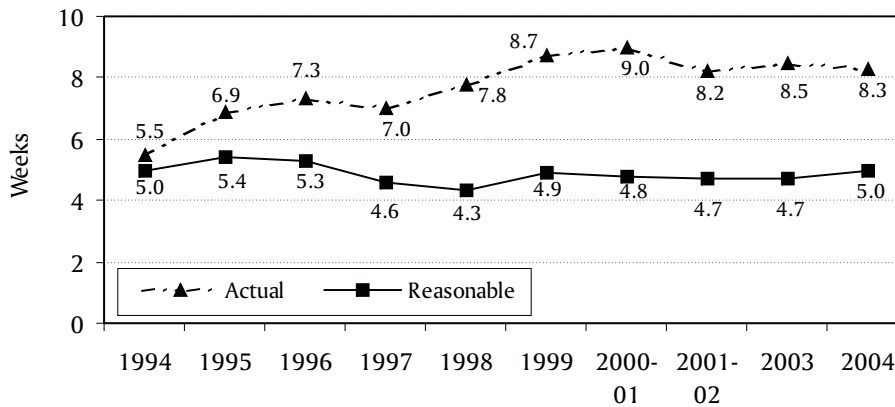
Source: The Fraser Institute, annual waiting list survey, 2004; Ramsay and Walker, 1997; and Naylor *et al.*, 1991.

Graph 9: British Columbia—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2004



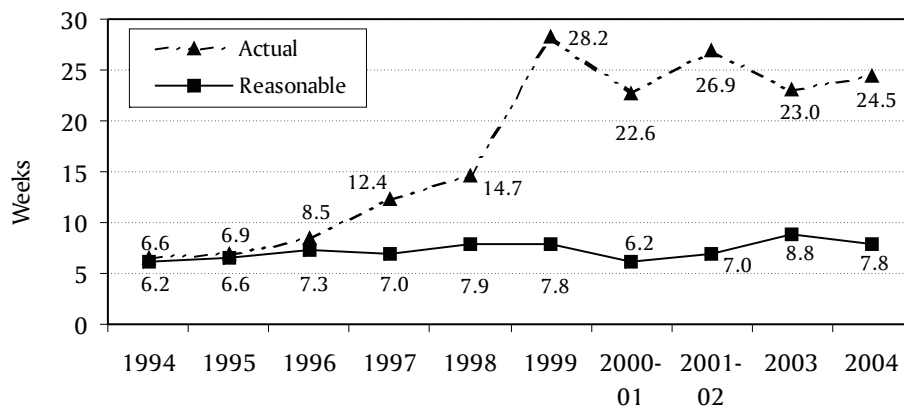
Source: The Fraser Institute's annual waiting list surveys, 1995-2004.

Graph 10: Alberta—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2004



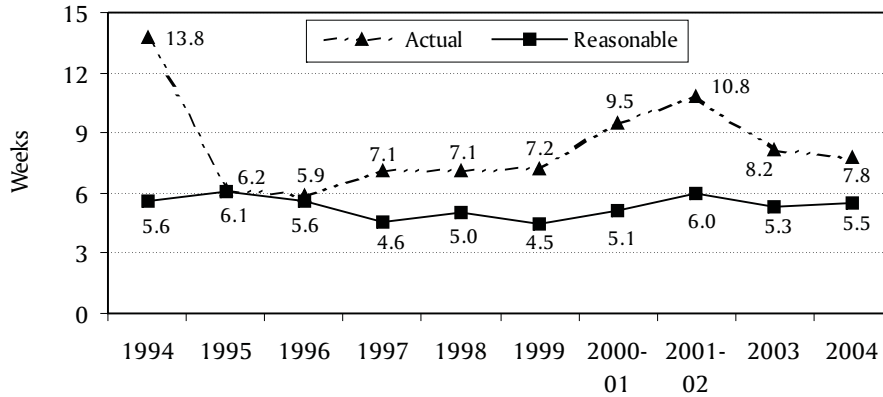
Source: The Fraser Institute's annual waiting list surveys, 1995-2004.

Graph 11: Saskatchewan—Actual Versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2004



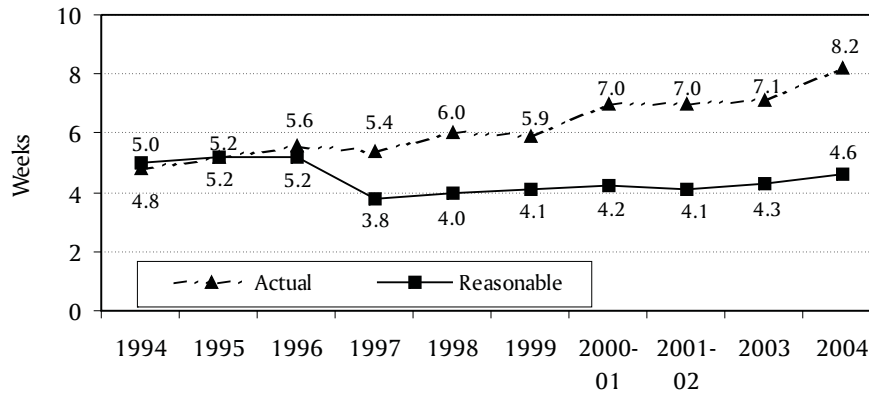
Source: The Fraser Institute's annual waiting list surveys, 1995-2004.

Graph 12: Manitoba—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2004



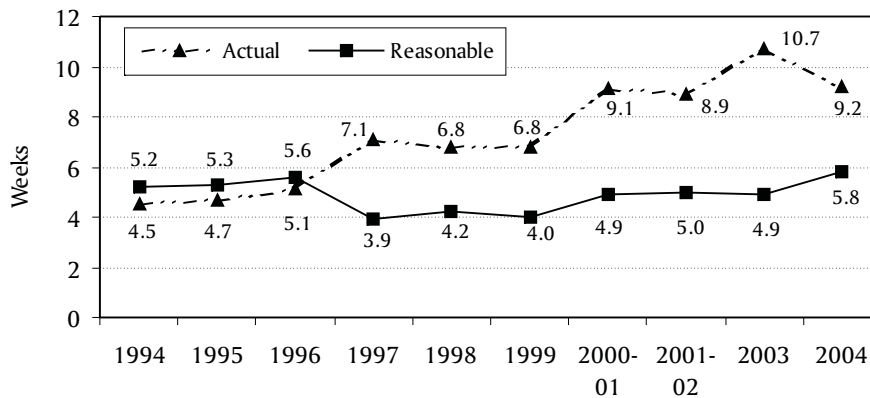
Source: The Fraser Institute's annual waiting list surveys, 1995-2004.

Graph 13: Ontario—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2004



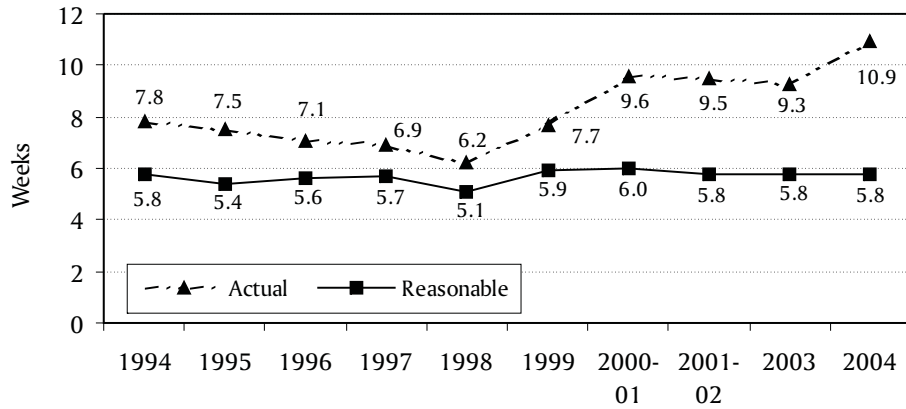
Source: The Fraser Institute's annual waiting list surveys, 1995-2004.

Graph 14: Quebec—Actual versus Reasonable Waits between Appointment with Specialist and Treatment, 1994 through 2004



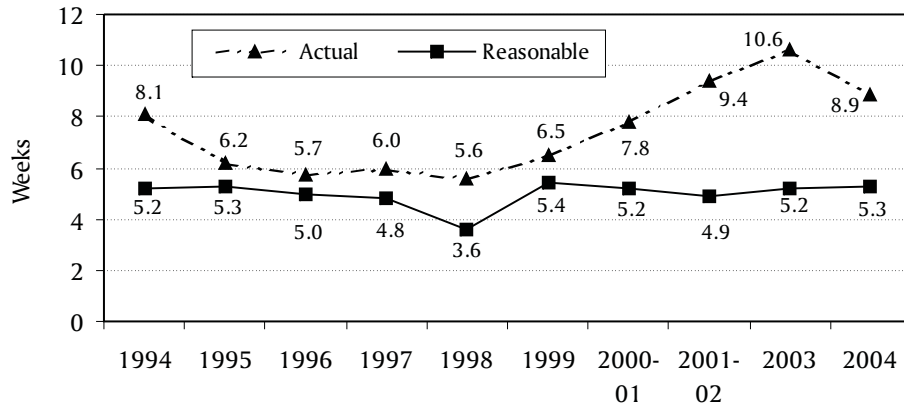
Source: The Fraser Institute's annual waiting list surveys, 1995-2004.

Graph 15: New Brunswick—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2004



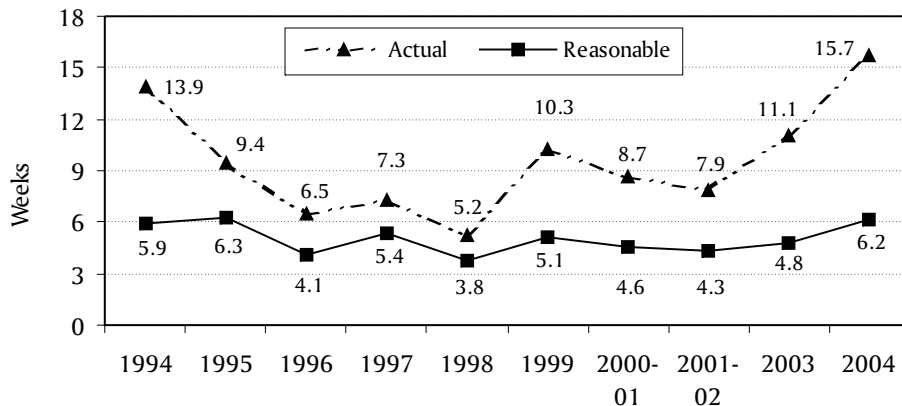
Source: The Fraser Institute's annual waiting list surveys, 1995-2004.

Graph 16: Nova Scotia—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2004



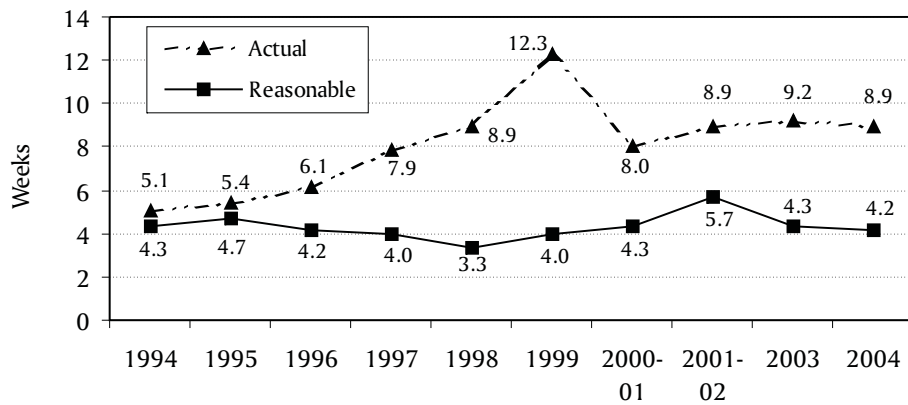
Source: The Fraser Institute's annual waiting list surveys, 1995-2004.

Graph 17: Prince Edward Island—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2004



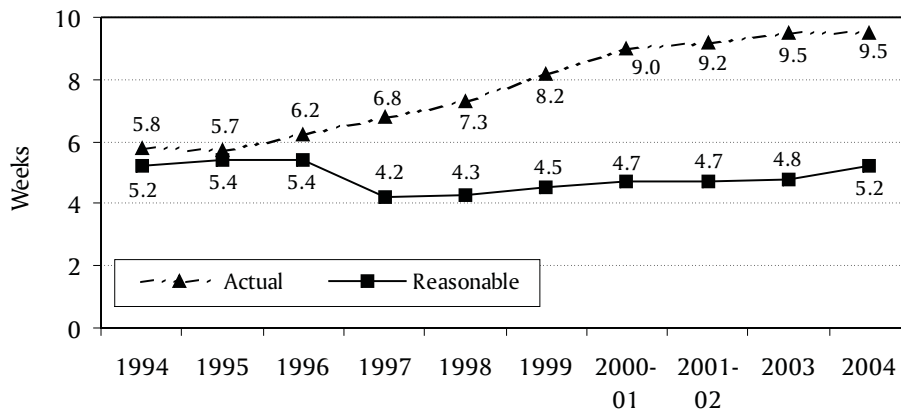
Source: The Fraser Institute's annual waiting list surveys, 1995-2004.

Graph 18: Newfoundland—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2004



Source: The Fraser Institute's annual waiting list surveys, 1995-2004.

Graph 19: Canada—Actual versus Reasonable Waits Between Appointment with Specialist and Treatment, 1994 through 2004



Source: The Fraser Institute's annual waiting list surveys, 1995-2004.

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Tables 1a–1c: Summary of Responses

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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)

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Table 16a: Acute Inpatient Procedures, 2002-03

Table 16b: Same Day Procedures, 2002-03

Table 1a: Summary of Responses, 2004—Response Rates (Percentages)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	62%	32%	57%	50%	44%	25%	31%	50%	100%	50%	41%
Gynaecology	30%	41%	32%	30%	35%	22%	33%	38%	40%	36%	32%
Ophthalmology	34%	39%	46%	36%	41%	24%	50%	17%	33%	50%	35%
Otolaryngology	45%	31%	56%	50%	36%	26%	54%	39%	0%	44%	35%
General Surgery	36%	32%	46%	26%	34%	21%	39%	52%	57%	29%	31%
Neurosurgery	43%	42%	71%	29%	34%	22%	40%	71%	—	100%	36%
Orthopaedic Surgery	47%	45%	30%	38%	43%	23%	54%	48%	67%	27%	38%
Cardiovascular Surgery	18%	41%	50%	30%	35%	20%	45%	80%	0%	50%	31%
Urology	44%	38%	50%	50%	39%	21%	19%	37%	50%	50%	35%
Internal Medicine	21%	19%	20%	20%	23%	18%	22%	26%	30%	26%	21%
Radiation Oncology	2%	29%	100%	50%	21%	28%	63%	33%	100%	50%	23%
Medical Oncology	28%	21%	—	0%	22%	17%	50%	56%	100%	33%	22%
Total	33%	32%	39%	30%	34%	22%	39%	38%	46%	36%	31%

Table 1b: Summary of Responses, 2004—Number of Responses

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	36	12	8	5	69	25	4	6	1	2	168
Gynaecology	52	45	12	15	209	80	10	15	2	8	448
Ophthalmology	51	30	11	10	146	62	11	7	1	6	335
Otolaryngology	33	11	5	8	74	45	7	7	0	4	194
General Surgery	56	36	17	14	178	87	12	22	4	7	433
Neurosurgery	12	8	5	2	21	11	2	5	—	2	68
Orthopaedic Surgery	71	46	7	13	165	64	15	13	2	4	400
Cardiovascular Surgery	9	9	6	3	46	19	5	12	0	2	111
Urology	29	13	5	7	79	30	3	7	1	3	177
Internal Medicine	55	42	12	21	160	70	7	22	3	7	399
Radiation Oncology	1	8	3	2	27	15	5	3	1	2	67
Medical Oncology	11	6	—	0	22	18	1	5	1	1	65
Total	416	266	91	100	1,196	526	82	124	16	48	2,865

Table 1c: Summary of Responses, 2004—Number of Questionnaires Mailed Out

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	58	37	14	10	156	100	13	12	1	4	405
Gynaecology	172	111	37	50	590	365	30	39	5	22	1,421
Ophthalmology	149	77	24	28	354	260	22	41	3	12	970
Otolaryngology	74	36	9	16	204	172	13	18	1	9	552
General Surgery	157	114	37	54	518	418	31	42	7	24	1,402
Neurosurgery	28	19	7	7	62	51	5	7	—	2	188
Orthopaedic Surgery	150	103	23	34	386	275	28	27	3	15	1,044
Cardiovascular Surgery	49	22	12	10	132	97	11	15	1	4	353
Urology	66	34	10	14	205	140	16	19	2	6	512
Internal Medicine	267	220	60	104	681	397	32	86	10	27	1,884
Radiation Oncology	50	28	3	4	129	53	8	9	1	4	289
Medical Oncology	40	29	—	5	98	109	2	9	1	3	296
Total	1,260	830	236	336	3,515	2,437	211	324	35	132	9,316

Table 2: Median Total Expected Waiting Time from Referral by GP to Treatment, by Specialty, 2004 (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	38.8	31.2	73.7	45.7	26.4	28.0	81.8	59.5	27.3	74.7	35.8
Gynaecology	14.6	18.6	25.6	13.3	14.1	14.1	12.0	12.7	14.6	12.5	14.8
Ophthalmology	20.0	17.6	42.5	17.8	29.1	31.3	25.6	21.7	72.2	33.5	28.7
Otolaryngology	20.7	15.5	59.8	9.3	16.0	9.8	11.8	18.8	—	9.2	15.8
General Surgery	11.6	10.9	20.4	7.0	8.7	9.4	11.7	8.2	14.9	10.9	9.9
Neurosurgery	28.8	30.3	27.5	11.0	24.8	14.7	50.1	12.1	—	16.1	22.7
Orthopaedic Surgery	50.2	43.1	86.2	31.5	30.5	32.8	32.9	42.9	52.5	36.9	37.9
Cardiovascular Surgery (Elective)	21.3	11.0	14.4	11.8	8.2	7.1	15.0	11.8	—	63.1	11.1
Urology	10.9	15.4	21.3	18.4	9.6	16.5	33.6	17.8	15.0	21.1	14.0
Internal Medicine	11.3	14.5	12.5	8.1	10.4	11.4	15.2	11.7	31.8	12.6	11.5
Radiation Oncology	3.5	8.3	7.1	4.3	8.0 ¹	9.5	12.6	3.9	9.1	11.2	7.8
Medical Oncology	3.5	7.7	—	—	5.0	5.3	4.5	8.5	5.6	14.2	5.6
Weighted Median	19.0	17.8	33.3	14.8	15.5	18.7	20.9	17.9	27.4	19.3	17.9

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 3.6 to 10.3 weeks for breast cancer, from 1.6 to 17.6 weeks for gynecologic cancer, from 0.9 to 6.4 weeks for lung cancer, and from 1.7 to 13.0 weeks for genitourinary cancer (including prostate) for the period March to May 2004.

Table 3: Median Patient Wait to See a Specialist after Referral from a GP, by Specialty, 2004 (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	16.0	13.0	14.0	22.0	12.0	12.0	59.0	25.0	5.0	29.5	16.2
Gynaecology	6.0	11.5	12.0	6.0	8.0	8.0	6.0	6.0	5.0	8.0	8.0
Ophthalmology	8.0	9.5	12.0	8.0	12.0	16.0	15.0	12.0	52.0	26.0	13.4
Otolaryngology	4.0	8.0	4.0	3.5	6.0	4.0	3.5	12.0	—	3.0	5.3
General Surgery	4.0	6.0	7.0	2.5	4.0	4.0	7.0	4.0	3.0	6.0	4.4
Neurosurgery	20.5	24.0	15.0	8.5	16.0	8.0	25.0	7.0	—	12.0	14.7
Orthopaedic Surgery	18.0	19.0	11.0	13.0	12.5	12.0	12.0	12.0	11.5	20.0	13.8
Cardiovascular Surgery	8.0	3.0	2.0	3.3	4.0	3.0	6.5	4.0	—	4.5	4.2
Urology	4.0	12.0	8.0	12.0	6.0	10.0	12.0	12.0	12.0	12.0	8.1
Internal Medicine	5.0	4.0	6.0	5.0	5.0	6.0	7.0	6.0	16.0	5.0	5.4
Radiation Oncology	2.0	3.3 ¹	4.0	1.5	2.0	1.0	2.0	1.0	1.0 ²	5.0 ³	1.8
Medical Oncology	2.0	3.5 ¹	—	—	2.5	4.0	3.0	7.0	3.0	8.0 ³	3.3
Weighted Median	7.3	9.5	8.8	6.9	7.3	9.5	10.0	9.0	11.8	10.3	8.4

¹Alberta Health and Wellness web site reports wait times of between 3 and 7 weeks for a radiation oncologist for breast cancer, between 4 and 11 weeks for a radiation oncologist for prostate cancer, and between 2 and 5 weeks for a medical oncologist for breast cancer at June 30, 2004.

²PEI Provincial Health Services Authority reports media wait times of 7 days (1 week) for a radiation oncologist for breast cancer and prostate cancer, and 1 day (0.14 weeks) for lung cancer in 2003-04.

³Newfoundland Cancer Treatment and Research Foundation reports median wait times of no more than 4 weeks for radiation oncology, and no more than 3-4 weeks for medical oncology.

Table 4: Median Patient Wait for Treatment after Appointment with Specialist, by Specialty, 2004 (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	22.8	18.2	59.7	23.7	14.4	16.0	22.8	34.5	22.3	45.2	19.6
Gynaecology	8.6	7.1	13.6	7.3	6.1	6.1	6.0	6.7	9.6	4.5	6.8
Ophthalmology	12.0	8.1	30.5	9.8	17.1	15.3	10.7	9.7	20.2	7.5	15.3
Otolaryngology	16.7	7.5	55.8	5.8	10.0	5.8	8.3	6.8	—	6.2	10.5
General Surgery	7.6	4.9	13.4	4.5	4.7	5.4	4.7	4.2	11.9	4.9	5.5
Neurosurgery	8.3	6.3	12.5	2.5	8.8	6.7	25.1	5.1	—	4.1	8.0
Orthopaedic Surgery	32.2	24.1	75.2	18.4	18.0	20.8	20.9	30.9	41.0	16.9	24.1
Cardiovascular Surgery (Urgent)	1.9	3.1	2.0	1.0	1.0	0.8	3.1	2.2	—	1.4	1.4
Cardiovascular Surgery (Elective)	13.3	8.0	12.4	8.6	4.2	4.1	8.5	7.8	—	58.6	6.9
Urology	6.9	3.4	13.3	6.4	3.6	6.5	21.6	5.8	3.0	9.1	5.9
Internal Medicine	6.3	10.5	6.5	3.1	5.4	5.4	8.2	5.7	15.8	7.6	6.1
Radiation Oncology	1.5	5.0	3.1	2.8	6.0	8.5	10.6	2.9	8.1	6.2	6.0
Medical Oncology	1.5	4.2	—	—	2.5	1.3	1.5	1.5	2.6	6.2	2.3
Weighted Median	11.6	8.3	24.5 ¹	7.8	8.2	9.2	10.9	8.9	15.7	8.9	9.5

¹Saskatchewan Surgical Care Network website reports that 50 percent of patients in Saskatoon and Regina had non-emergent surgery within 10.1 weeks between October 1, 2003 and March 31, 2004. For an extensive explanation, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5a: Plastic Surgery (2004)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Mammoplasty	34.0	27.5	94.0	40.0	20.0	30.0	25.0	82.0	52.0	91.0
Neurolysis	12.0	12.0	14.0	12.0	12.0	11.0	15.0	12.0	18.0	31.0
Blepharoplasty	16.0	16.0	12.0	16.0	10.0	8.0	24.0	24.0	16.0	33.0
Rhinoplasty	20.0	16.0	96.0	16.0	12.0	13.0	24.0	24.0	—	65.0
Scar Revision	20.0	14.0	28.0	26.0	12.0	13.0	32.5	38.0	16.0	52.0
Hand Surgery	12.0	12.0	39.5	16.0	12.0	10.0	19.0	12.0	18.0	29.0
Craniofacial Procedures	19.0	20.0	32.0	40.0	7.0	24.0	19.0	7.3	—	38.0
Skin Cancer and other Tumors	5.0	2.5	7.0	8.0	5.0	6.0	8.5	3.5	33.0	27.5
Weighted Median	22.8 ¹	18.2 ²	59.7 ³	23.7	14.4	16.0	22.8	34.5	22.3	45.2

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

¹BC Ministry of Health web site reports a 5.4 week median wait time for plastic surgery at April 30, 2004. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness web site reports that in 11 facilities across the province, 90% of patients waiting for non-emergent plastic surgery were treated within a range of 9 to 58 weeks for the quarter ending June 30, 2004.

³Saskatchewan Surgical Care Network web site reports that 29 percent of patients in Saskatoon and Regina waited less than 3 weeks, 37 percent waited between 3 weeks and 6 months, 17 percent waited between 7 and 12 months, 6 percent waited between 13 and 18 months, and 10 percent waited more than 18 months for non-emergent plastic surgery between October 2003 and March 2004. For an extensive explanation, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5b: Gynaecology (2004)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Dilation & Curettage	5.0	6.0	2.0	6.0	4.0	4.0	5.5	4.5	4.0	3.8
Tubal Ligation	10.0	8.0	12.0 ³	7.5	6.0	7.0	7.0	6.0	7.0	4.0
Hysterectomy (Vaginal/Abdominal)	12.0	8.0	24.0 ³	8.0	8.0	8.0	6.5	9.0	16.0	6.0
Vaginal Repair	12.0	8.5	32.0	8.0	8.0	8.0	6.5	10.0	15.0	6.0
Tuboplasty	10.0	10.0	41.3	21.0	8.0	10.0	11.0	12.5	—	7.0
Laparoscopic Procedures	8.0	7.0	20.0	7.0	7.0	6.0	6.0	6.0	6.5	4.0
Hysteroscopic Procedures	8.0	8.0	9.0	7.0	6.0	6.0	4.5	6.0	6.5	3.8
Weighted Median	8.6 ¹	7.1 ²	13.6 ³	7.3	6.1	6.1	6.0	6.7	9.6	4.5

¹BC Ministry of Health web site reports a 4.1 week median wait time for gynecological surgery at April 30, 2004. For an extensive explanation, please refer to "Verification of current data with governments—British Columbia."

²Alberta Health and Wellness web site reports that in 19 facilities across the province, 90% of patients waiting for non-emergent gynecological surgery were treated within a range of 0 to 39 weeks for the quarter ending June 30, 2004.

³Saskatchewan Surgical Care Network website reports that 31 percent of patients in Saskatoon and Regina waited less than 3 weeks, 45 percent waited between 3 weeks and 6 months, 10 percent waited between 7 and 12 months, 6 percent waited between 13 and 18 months, and 8 percent waited more than 18 months for non-emergent obstetrics and gynaecology procedures between October 2003 and March 2004. The percentages for tubal ligation are reported to be 20%, 43%, 20%, 10%, and 7% respectively. The percentages for hysterectomy are reported to be 17%, 53%, 13%, 7%, and 10% respectively. For an extensive explanation, please refer to "Verification of current data with governments—Saskatchewan."

Table 5c: Ophthalmology (2004)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Cataract Removal	13.3 ¹	10.5 ²	36.0 ³	12.0	23.0	16.0 ⁴	12.0	12.0	20.0	7.0
Cornea Transplant	48.5 ¹	10.0	52.0	65.0	39.0	53.0	50.0	—	100.0	16.0
Cornea—Pterygium	10.0	8.0	12.0	4.0	16.0	11.0	10.0	10.0	20.0	8.0
Iris, Ciliary Body, Sclera, Anterior Chamber	12.0	8.0	31.0	—	8.0	8.0	6.0	4.0	—	6.8
Retina, Choroid, Vitreous	5.0	3.8	2.5 ³	5.0	4.0	4.0	1.8	4.0	—	6.0
Lacrimal Duct	12.0	8.0	24.0	14.0	8.0	14.0	12.0	12.0	—	21.0
Strabismus	12.0	8.0	21.0	—	26.0	18.0	13.3	11.0	20.0	12.0
Operations on Eyelids	12.0	8.0	8.0	9.5	6.0	10.0	8.0	6.0	20.0	9.0
Glaucoma	5.5	6.0	9.0	10.0	8.0	6.0	5.0	4.0	20.0	4.3
Weighted Median	12.0 ¹	8.1 ²	30.5 ³	9.8	17.1	15.3	10.7	9.7	20.2	7.5

Note: Weighted median does not include treatment for glaucoma.

¹BC Ministry of Health web site reports median wait times of 10.1 weeks for ophthalmology, 11.4 weeks for cataract surgery, and 23.6 weeks for cornea transplant at April 30, 2004. For an extensive explanation, please refer to "Verification of current data with governments—British Columbia."

²Alberta Health and Wellness web site reports that in 14 facilities across the province, 90% of patients waiting for non-emergent eye surgery were treated within a range of 10 to 40 weeks, and within a range of 1 to 40 weeks at 13 facilities for cataract surgery for the quarter ending June 30, 2004.

³Saskatchewan Surgical Care Network web site reports that 9 percent of patients in Saskatoon and Regina waited less than 3 weeks, 42 percent waited between 3 weeks and 6 months, 34 percent waited between 7 and 12 months, 11 percent waited between 13 and 18 months, and 3 percent waited more than 18 months for non-emergent ophthalmology procedures between October 2003 and March 2004. The percentages for cataract surgery are reported to be 5%, 42%, 38%, 12%, and 3% respectively. The percentages for operations on vitreous are reported to be 70%, 30%, 0%, 0%, and 0% respectively. For an extensive explanation, please refer to "Verification of current data with governments—Saskatchewan."

⁴Quebec Ministry of Health and Social Services web site reports a wait time of 6 months for cataract treatment.

Table 5d: Otolaryngology (2004)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Myringotomy	10.5	4.0	5.0 ³	4.5	8.0	5.0	8.0	3.5	—	3.0
Tympanoplasty	20.0	6.0	90.0	4.0	10.0	8.0	12.0	8.0	—	3.5
Thyroid, Parathyroid, and Other Endocrine Glands	16.0	6.0	42.5	12.0	10.0	6.0	4.0	7.0	—	11.5
Tonsillectomy and/or Adenoidectomy	16.0	12.0	90.0 ³	6.0	12.0	6.5	8.0	10.0	—	11.0
Rhinoplasty and/or Septal Surgery	24.0	6.0	90.0	6.0	9.5	7.5	12.0	8.0	—	4.0
Operations on Nasal Sinuses	20.0	6.0	90.0	6.0	10.0	7.0	8.0	8.0	—	3.5
Weighted Median	16.7 ¹	7.5 ²	55.8 ³	5.8	10.0	5.8	8.3	6.8	—	6.2

¹BC Ministry of Health web site reports a 7.0 week median wait time for ear, nose, and throat surgery at April 30, 2004. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness web site reports that in 12 facilities across the province, 90% of patients waiting for non-emergent ear, nose, and throat surgery were treated within a range of 7 to 38 weeks for the quarter ending June 30, 2004.

³Saskatchewan Surgical Care Network web site reports that 31 percent of patients in Saskatoon and Regina waited less than 3 weeks, 40 percent waited between 3 weeks and 6 months, 4 percent waited between 7 and 12 months, 7 percent waited between 13 and 18 months, and 17 percent waited more than 18 months for non-emergent otolaryngology procedures between October 2003 and March 2004. The percentages for myringotomy are reported to be 46%, 53%, 0%, 0%, and 0% respectively. The percentages for tonsillectomy with or without adenoidectomy are reported to be 7%, 27%, 11%, 21%, and 34% respectively. For an extensive explanation, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5e: General Surgery (2004)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Hernia/Hydrocele	11.0	6.0	26.0 ³	5.5	5.0	8.0	6.0	6.0	10.0	6.0
Cholecystectomy	8.0	5.5	24.0	4.0	4.0	4.5	4.0	6.0	9.0	6.0
Colonoscopy	12.0	6.0	6.0	5.5	6.0	6.3	6.0	4.0	25.0	6.5
Intestinal Operations	4.0	4.0	6.0	3.0	4.0	4.0	3.0	3.0	5.5	3.0
Haemorrhoidectomy	12.0	6.0	38.0	6.0	6.0	8.0	7.5	7.0	8.0	7.0
Breast Biopsy	3.0	2.0	2.8 ³	2.0	2.5	2.0	3.0	2.5	2.5	1.5
Mastectomy	3.0	2.0	2.5 ³	3.0	2.0	2.0	2.0	2.0	2.8	1.5
Bronchus and Lung	6.0	2.0	3.0	6.0	4.0	3.0	2.0	—	3.0	0.8
Aneurysm Surgery	9.0	2.0	4.0	6.0	5.0	8.0	4.0	0.0	—	2.0
Varicose Veins	9.0	8.0	27.0	13.5	6.0	10.0	6.0	4.0	10.0	13.5
Weighted Median	7.6 ¹	4.9 ²	13.4 ³	4.5	4.7	5.4	4.7	4.2	11.9	4.9

¹BC Ministry of Health web site reports a 3.7 week median wait time for general surgery at April 30, 2004. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness web site reports that in 21 facilities across the province, 90% of patients waiting for non-emergent general surgery were treated within a range of 3 to 62 weeks for the quarter ending June 30, 2004.

³Saskatchewan Surgical Care Network web site reports that 44 percent of patients in Saskatoon and Regina waited less than 3 weeks, 42 percent waited between 3 weeks and 6 months, 8 percent waited between 7 and 12 months, 3 percent waited between 13 and 18 months, and 4 percent waited more than 18 months for non-emergent general surgery between October 2003 and March 2004. The percentages for hernia repair are reported to be 24%, 52%, 13%, 5%, and 6% respectively. The percentages for breast biopsy are reported to be 78%, 22%, 0%, 0%, and 0% respectively. The percentages for mastectomy are reported to be 69%, 25%, 2%, 1%, and 2% respectively. For an extensive explanation, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5f: Neurosurgery (2004)—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	7.0	8.0	3.5	12.0	4.0	9.0	4.0	—	6.5
Disc Surgery/ Laminectomy	12.0	10.0	24.0 ³	3.0	10.0	10.0	57.5	6.0	—	6.8
Elective Cranial Bone Flap	6.0	4.5	8.0	1.8	7.0	4.0	10.5	5.0	—	1.5
Aneurysm Surgery	6.0	9.0	9.0	2.5	8.0	7.0	14.0	4.0	—	0.8
Carotid endarterectomy	6.0	2.0	8.0	2.0	4.0	8.0	12.0	2.5	—	—
Weighted Median	8.3 ¹	6.3 ²	12.5 ³	2.5	8.8	6.7	25.1	5.1	—	4.1

¹BC Ministry of Health web site reports a 3.3 week median wait time for neurosurgery at April 30, 2004. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness web site reports that in 4 facilities across the province, 90% of patients waiting for non-emergent neurosurgery were treated within a range of 9 to 16 for the quarter ending June 30, 2004.

³Saskatchewan Surgical Care Network web site reports that 42 percent of patients in Saskatoon and Regina waited less than 3 weeks, 35 percent waited between 3 weeks and 6 months, 13 percent waited between 7 and 12 months, 4 percent waited between 13 and 18 months, and 5 percent waited more than 18 months for non-emergent neurosurgery between October 2003 and March 2004. The percentages for laminectomy/diskectomy are reported to be 33%, 42%, 14%, 4%, and 6% respectively. For an extensive explanation, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5g: Orthopaedic Surgery (2004)—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	12.0	26.0	10.0	12.0	16.0	9.0	12.0	30.0	6.0
Removal of Pins	16.0	12.0	65.0	10.5	12.0	20.0	14.0	14.0	30.0	20.0
Arthroplasty (Hip, Knee, Ankle, Shoulder)	52.0 ¹	37.0 ²	104.0 ³	27.0	24.0	24.0 ⁴	30.0	50.0	49.5	28.0
Arthroplasty (Interphalangeal, Metatarsophalangeal)	13.0	12.0	28.0	9.0	16.0	20.0	18.5	19.5	34.5	6.0
Hallux Valgus/Hammer Toe	16.0	12.0	104.0	12.0	12.0	22.0	18.0	12.0	30.0	22.0
Digit Neuroma	10.5	12.0	52.0	11.3	12.0	20.0	13.0	12.0	30.0	6.0
Rotator Cuff Repair	18.0	14.0	26.0	11.3	15.0	16.5	20.0	27.5	35.0	14.0
Ostectomy (All Types)	20.0	16.0	41.0	16.0	12.0	19.0	20.0	27.0	24.0	16.0
Routine Spinal Instability	52.0	22.0	106.0	12.0	16.0	24.0	25.0	24.0	52.5	10.0
Weighted Median	32.2 ¹	24.1 ²	75.2 ³	18.4	18.0	20.8	20.9	30.9	41.0	16.9

¹BC Ministry of Health web site reports median wait times of an 8.4 weeks for orthopaedic surgery, 22.0 weeks for hip replacement, and 30.3 weeks for knee replacement at April 30, 2004. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness web site reports that in 16 facilities across the province, 90% of patients waiting for non-emergent orthopaedic surgery were treated within a range of 9 to 54 weeks, and within a range of 0 to 65 weeks at 12 facilities for hip replacement and knee replacement for the quarter ending June 30, 2004.

³Saskatchewan Surgical Care Network web site reports that 14 percent of patients in Saskatoon and Regina waited less than 3 weeks, 47 percent waited between 3 weeks and 6 months, 16 percent waited between 7 and 12 months, 11 percent waited between 13 and 18 months, and 12 percent waited more than 18 months for non-emergent orthopaedic surgery between October 2003 and March 2004. The percentages for total hip replacement are reported to be 4%, 45%, 21%, 13%, and 17% respectively. The percentages for total knee replacement are reported to be 2%, 30%, 27%, 17%, and 25% respectively. For an extensive explanation, please refer to “Verification of current data with governments—Saskatchewan.”

⁴Quebec Ministry of Health and Social Services web site reports a wait time of 3 months for arthroplasty of the hip or knee.

Table 5h: Cardiovascular Surgery (2004)—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	0.5	0.0	0.5	0.1	0.0	0.0	0.0	0.2	—	0.5
	Valves & Septa of the Heart	0.0	0.0	0.5	0.1	0.0	0.0	0.0	0.2	—	0.5
	Aneurysm Surgery	0.5	0.0	0.5	0.0	0.0	0.0	0.0	0.2	—	1.0
	Carotid Endarterectomy	1.0	0.5	0.3	0.0	0.0	0.0	0.2	0.6	—	0.5
	Pacemaker Operations	0.3	0.5	0.5	—	0.1	0.0	0.0	0.2	—	—
	Weighted Median	0.3	0.2	0.5	0.1 ⁴	0.0	0.0	0.0	0.2	—	0.5
Urgent	Coronary Artery Bypass	4.0	4.8	2.0 ³	0.7	1.0	1.0	5.0	2.0 ⁷	—	1.5
	Valves & Septa of the Heart	2.0	3.8	2.0	1.2	1.0	0.8	5.0	3.0	—	1.5
	Aneurysm Surgery	2.0	2.5	1.8	1.0	1.5	0.5	2.0	2.0	—	1.0
	Carotid Endarterectomy	2.0	2.0	1.0	4.0	1.5	1.0	2.3	5.0	—	0.5
	Pacemaker Operations	0.9	1.5	2.0	—	1.0	0.5	1.8	2.0	—	—
	Weighted Median	1.9	3.1	2.0 ³	1.0 ⁴	1.0	0.8	3.1	2.2	—	1.4
Elective	Coronary Artery Bypass	16.0	9.0 ²	16.0 ³	8.0	4.0 ⁵	4.0	12.0	10.3 ⁷	—	62.0
	Valves & Septa of the Heart	16.0	9.0	16.0	10.0	4.5	4.0	12.0	6.0	—	62.0
	Aneurysm Surgery	8.0	6.0	12.0	10.0	6.5	6.0	6.0	9.0	—	6.5
	Carotid Endarterectomy	6.0	5.0	6.0	10.0	8.0	6.0	5.0	12.0	—	5.0
	Pacemaker Operations	12.0	7.0	8.0	—	4.0	4.0	6.0	6.0	—	—
	Weighted Median	13.3 ¹	8.0 ²	12.4 ³	8.6 ⁴	4.2	4.1 ⁶	8.5	7.8	—	58.6

¹BC Ministry of Health web site reports median wait times of 14.9 weeks for cardiac surgery and 3.0 weeks for vascular surgery at April 30, 2004. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness web site reports that in 2 facilities across the province, 90% of patients waiting for non-emergent cardiac surgery were treated within a range of 11 to 13 weeks, within a range of 6 to 30 weeks at 6 facilities for non-emergent vascular surgery, within a range of 5 to 12 weeks at 3 facilities for non-emergent thoracic surgery, and within a range of 9 to 10 weeks at 2 facilities for non-emergent coronary artery bypass surgery for the quarter ending June 30, 2004.

³Saskatchewan Surgical Care Network web site reports that 62 percent of patients in Saskatoon and Regina waited less than 3 weeks, 32 percent waited between 3 weeks and 6 months, 5 percent waited between 7 and 12 months, 2 percent waited between 13 and 18 months, and 0 percent waited more than 18 months for non-emergent cardiovascular surgery between October 2003 and March 2004. The percentages for bypass surgery are reported to be 56%, 40%, 3%, 1%, and 0% respectively. For an extensive explanation, please refer to “Verification of current data with governments—Saskatchewan.”

⁴Manitoba Health web site reports a median waiting time of 19.5 days (2.8 weeks) for all cardiac surgery cases performed in Winnipeg for the quarter ending June 2004.

⁵Cardiac Care Network of Ontario reports a median wait time for bypass surgery of 32 days (4.6 weeks) between January and March 2004.

⁶Quebec Ministry of Health and Social Services web site reports a wait time of 3 months for cardiac surgery.

⁷Nova Scotia Department of Health reports urgent wait times of 4.4 days (0.6 weeks) and elective wait times of 25 days (3.6 weeks) for cardiovascular surgery as of June 2004.

Table 5i: Urology (2004)—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	70.0 ³	6.0	6.0	11.0	16.0	6.0	10.0	12.0
Radical Prostatectomy	6.0	6.0	4.0 ³	4.0	6.0	6.0	8.0	8.0	8.0	4.0
Transurethral Resection—Bladder	5.0	4.0	4.0 ³	4.0	4.0	5.0	8.0	4.0	5.0	4.0
Radical Cystectomy	6.0	5.5	5.0	4.0	6.0	4.0	8.0	6.0	8.0	5.0
Cystoscopy	6.0	3.0	2.0 ³	6.3	3.0	6.0	24.0	6.0	0.0	10.0
Hernia/Hydrocele	12.0	6.0	100.0	8.5	6.0	20.0	24.0	6.0	10.0	8.0
Bladder Fulguration	6.0	3.3	4.0	7.0	4.0	4.0	12.0	4.0	0.0	4.0
Ureteral Reimplantation for Reflux	13.0	6.0	50.0	8.0	8.0	8.0	45.0	6.0	—	16.0
Weighted Median	6.9 ¹	3.4 ²	13.3 ³	6.4	3.6	6.5	21.6	5.8	3.0	9.1

¹BC Ministry of Health web site reports a 3.4 week median wait time for urological surgery at April 30, 2004. For an extensive explanation, please refer to “Verification of current data with governments—British Columbia.”

²Alberta Health and Wellness web site reports that in 14 facilities across the province, 90% of patients waiting for non-emergent urological surgery were treated within a range of 4 to 31 weeks for the quarter ending June 30, 2004.

³Saskatchewan Surgical Care Network web site reports that 37 percent of patients in Saskatoon and Regina waited less than 3 weeks, 52 percent waited between 3 weeks and 6 months, 4 percent waited between 7 and 12 months, 3 percent waited between 13 and 18 months, and 4 percent waited more than 18 months for non-emergent urology procedures between October 2003 and March 2004. The percentages for prostatectomy are reported to be 19%, 68%, 4%, 5%, and 5% respectively. The percentages for resection of bladder are reported to be 58%, 42%, 0%, 0%, and 0% respectively. The percentages for cystoscopy are reported to be 43%, 51%, 3%, 2%, and 1% respectively. For an extensive explanation, please refer to “Verification of current data with governments—Saskatchewan.”

Table 5j: Internal Medicine (2004)—Median Patient Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Colonoscopy	6.0	12.0	6.5	3.0	6.0	6.0	7.0	6.0	16.0	7.0
Angiography /Angioplasty	8.0	6.0	6.0	6.0	4.0	6.0 ¹	24.0	6.0	17.0	13.5
Bronchoscopy	3.5	3.5	5.5	1.3	4.0	3.0	1.5	3.5	23.5	2.0
Gastroscopy	4.5	8.0	8.0	3.0	4.0	4.0	2.0	4.0	10.0	7.0
Weighted Median	6.3	10.5	6.5	3.1	5.4	5.4	8.2	5.7	15.8	7.6

¹Quebec Ministry of Health and Social Services reports a wait time of 2 months for angioplasty.

Table 5k: Radiation Oncology (2004)—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	—	3.0	3.0	2.9	4.0	3.0	7.3	2.5	2.0	2.0
Cancer of the Cervix	—	3.0	3.5	1.8	2.3	4.0	8.0	1.3	2.0	2.0
Lung Cancer	1.5	3.0	2.5	2.8	4.0	4.0	8.0	3.0	2.5 ⁵	3.0
Prostate Cancer	—	6.0 ²	4.0	2.9	8.0	12.0	18.0	2.8	14.0 ⁵	7.0
Breast Cancer	—	6.0 ²	2.5	2.8	6.5	12.0	6.0	3.0	10.0 ⁵	8.5 ⁶
Early Side Effects from Treatment	0.5	1.0	0.5	0.0	1.0	1.0	0.5	0.5	0.5	0.3
Late Side Effects from Treatment	1.5	2.0	2.0	1.0	1.3	1.0	2.0	1.0	0.5	1.0
Weighted Median	1.5 ¹	5.0	3.1	2.8 ³	6.0	8.5 ⁴	10.6	2.9	8.1	6.2

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

¹BC Ministry of Health web site reports a 6 day (0.9 week) median wait time for radiotherapy for the three months ending April 22, 2004. 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 2 to 5 weeks for breast cancer and prostate cancer at June 30, 2004.

³Manitoba Health web site reports a 1 week median wait time for radiotherapy for the quarter ending March 31, 2004.

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

⁵PEI Provincial Health Authority reports median wait times of 18 days (2.6 weeks) for treatment of lung cancer, 118 days (16.9 weeks) for treatment of prostate cancer, and 75 days (10.7 weeks) for treatment of breast cancer in 2003-04.

⁶Newfoundland Cancer Treatment and Research Foundation reports a median patient wait of no more than 4 to 6 weeks for treatment of breast cancer.

Table 5l: Medical Oncology (2004)—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	1.8	3.0	—	—	3.0	2.0	1.5	—	3.0	3.0
Cancer of the Cervix	1.8	2.0	—	—	3.0	1.5	1.5	2.0	3.0	—
Lung Cancer	1.5	3.5	—	—	2.4	1.3	1.5	1.0	3.0	3.0
Breast Cancer	1.5	5.0 ¹	—	—	2.5	1.3	1.5	2.0	2.0	9.0
Side Effects from Treatment	0.0	0.0	—	—	0.4	0.0	0.5	0.0	0.1	0.5
Weighted Median	1.5	4.2	—	—	2.5	1.3	1.5	1.5	2.6	6.2 ²

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

¹Alberta Health and Wellness web site reports a wait time of 1 week for breast cancer at December 31, 2003.

²Newfoundland Cancer Treatment and Research Foundation reports a median patient wait for treatment of no more than 2 weeks for medical oncology.

Table 6: Comparison of Median Weeks Waited to Receive Treatment after Appointment with Specialist, by Selected Specialties, 2003 and 2004

	British Columbia			Alberta			Saskatchewan			Manitoba			Ontario		
	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg
Plastic Surgery	22.8	25.5	-11%	18.2	14.2	28%	59.7	32.8	82%	23.7	19.3	23%	14.4	9.3	54%
Gynaecology	8.6	8.1	7%	7.1	7.7	-7%	13.6	16.7	-19%	7.3	7.8	-6%	6.1	5.9	2%
Ophthalmology	12.0	9.9	21%	8.1	6.4	27%	30.5	30.3	0%	9.8	14.5	-33%	17.1	14.4	19%
Otolaryngology	16.7	12.6	32%	7.5	9.8	-24%	55.8	46.6	20%	5.8	7.9	-26%	10.0	7.2	40%
General Surgery	7.6	7.2	6%	4.9	5.4	-9%	13.4	14.4	-7%	4.5	5.0	-10%	4.7	4.3	8%
Neurosurgery	8.3	9.7	-14%	6.3	6.1	4%	12.5	6.8	83%	2.5	—	—	8.8	7.8	14%
Orthopaedic Surgery	32.2	24.7	30%	24.1	18.1	33%	75.2	53.4	41%	18.4	15.6	18%	18.0	14.4	25%
Cardiovascular Surgery (Urgent)	1.9	3.2	-42%	3.1	11.2	-73%	2.0	2.4	-19%	1.0	2.0	-49%	1.0	1.1	-4%
Cardiovascular Surgery (Elective)	13.3	16.6	-19%	8.0	20.6	-61%	12.4	30.0	-59%	8.6	5.0	72%	4.2	5.3	-21%
Urology	6.9	6.9	-1%	3.4	4.3	-20%	13.3	10.5	27%	6.4	3.8	69%	3.6	3.5	1%
Internal Medicine	6.3	7.4	-15%	10.5	8.3	28%	6.5	7.6	-15%	3.1	4.6	-31%	5.4	5.0	9%
Radiation Oncology	1.5	1.3	20%	5.0	10.4	-52%	3.1	4.3	-28%	2.8	7.7	-64%	6.0	5.6	7%
Medical Oncology	1.5	1.5	1%	4.2	4.0	5%	—	—	—	—	—	—	2.5	2.7	-8%
Weighted Median	11.6	10.9	7%	8.3	8.5	-2%	24.5	23.0	7%	7.8	8.2	-4%	8.2	7.1	16%

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, 2003 and 2004

	Quebec			New Brunswick			Nova Scotia			Prince Edward Island			Newfoundland		
	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg
Plastic Surgery	16.0	18.4	-13%	22.8	16.6	38%	34.5	44.9	-23%	22.3	—	—	45.2	50.8	-11%
Gynaecology	6.1	7.1	-15%	6.0	10.4	-43%	6.7	5.6	20%	9.6	5.7	67%	4.5	4.9	-9%
Ophthalmology	15.3	19.2	-20%	10.7	14.4	-26%	9.7	9.4	4%	20.2	26.1	-23%	7.5	8.0	-6%
Otolaryngology	5.8	9.0	-35%	8.3	9.3	-11%	6.8	5.8	17%	—	—	—	6.2	12.8	-51%
General Surgery	5.4	7.2	-24%	4.7	4.1	13%	4.2	5.4	-23%	11.9	9.7	23%	4.9	4.9	0%
Neurosurgery	6.7	7.3	-8%	25.1	17.1	46%	5.1	3.7	36%	—	—	—	4.1	1.7	142%
Orthopaedic Surgery	20.8	16.2	28%	20.9	10.7	95%	30.9	33.4	-7%	41.0	14.9	174%	16.9	11.8	43%
Cardiovascular Surgery (Urgent)	0.8	0.7	5%	3.1	1.2	156%	2.2	3.0	-26%	—	—	—	1.4	1.0	44%
Cardiovascular Surgery (Elective)	4.1	6.4	-36%	8.5	19.5	-57%	7.8	24.6	-68%	—	—	—	58.6	52.1	12%
Urology	6.5	8.1	-19%	21.6	10.2	112%	5.8	4.9	17%	3.0	3.8	-21%	9.1	7.0	29%
Internal Medicine	5.4	4.8	12%	8.2	5.6	45%	5.7	6.2	-9%	15.8	15.6	2%	7.6	5.8	31%
Radiation Oncology	8.5	7.7	10%	10.6	4.9	116%	2.9	5.1	-44%	8.1	—	—	6.2	6.4	-2%
Medical Oncology	1.3	2.0	-36%	1.5	2.5	-40%	1.5	7.0	-79%	2.6	2.0	29%	6.2	5.8	8%
Weighted Median	9.2	10.7	-14%	10.9	9.3	17%	8.9	10.6	-16%	15.7	11.1	41%	8.9	9.2	-2%

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 2004—Proportion of Survey Waiting Times that Fall Within Given Ranges

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
0 - 3.99 weeks	17.1%	21.7%	21.6%	25.3%	23.1%	24.8%	21.0%	25.6%	24.0%	34.4%
4 - 7.99 weeks	23.1%	30.1%	18.5%	26.4%	31.5%	27.7%	24.0%	29.4%	13.0%	30.1%
8 - 12.99 weeks	25.0%	23.7%	15.7%	23.5%	24.5%	21.7%	25.7%	22.1%	23.0%	13.5%
13 - 25.99 weeks	18.2%	15.9%	9.8%	15.6%	11.4%	13.7%	16.6%	8.8%	26.0%	8.5%
26 - 51.99 weeks	9.2%	4.9%	10.7%	7.3%	6.4%	6.4%	7.9%	7.0%	8.0%	6.4%
1 year plus	7.4%	3.7%	23.7%	2.0%	3.1%	5.7%	4.8%	7.1%	6.0%	7.1%

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

Table 8: Median Reasonable Patient Wait for Treatment after Appointment with Specialist 2004 (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	9.9	10.7	18.1	10.0	8.8	7.1	12.8	12.2	10.0	5.3	9.4
Gynaecology	5.5	5.6	9.5	5.4	4.7	6.0	5.8	4.6	6.8	3.1	5.4
Ophthalmology	7.2	7.2	10.6	7.4	6.6	9.6	7.5	7.7	12.0	6.5	8.3
Otolaryngology	7.0	4.7	12.2	6.5	5.3	4.7	7.0	5.7	—	3.0	5.6
General Surgery	4.3	4.5	7.0	3.7	3.6	4.0	4.4	3.5	3.9	3.3	4.0
Neurosurgery	4.2	4.1	6.0	1.9	4.2	3.6	7.9	3.7	—	—	4.1
Orthopaedic Surgery	8.0	9.0	12.5	10.4	9.6	10.2	8.1	11.0	10.7	8.2	9.6
Cardiovascular Surgery (Urgent)	1.0	0.8	2.0	2.0	1.0	0.3	1.5	2.0	—	1.4	0.9
Cardiovascular Surgery (Elective)	5.9	6.1	8.2	11.5	4.6	3.3	5.9	7.2	—	11.4	4.9
Urology	2.6	2.3	4.0	3.5	2.5	3.3	7.6	3.4	2.2	4.5	3.1
Internal Medicine	2.0	3.7	3.2	2.0	2.8	3.5	2.8	3.8	7.1	3.1	3.0
Radiation Oncology	2.0	3.5	7.0	5.1	2.8	3.6	3.7	3.2	3.3	3.6	3.4
Medical Oncology	2.0	1.9	—	—	2.0	1.8	1.5	2.4	3.6	3.7	2.0
Weighted Median	5.0	5.0	7.8	5.5	4.6	5.8	5.8	5.3	6.2	4.2	5.2

Table 9a: Plastic Surgery (2004)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Mammoplasty	12.0	13.5	25.0	10.0	12.0	9.0	13.0	13.0	10.0	12.0
Neurolysis	6.0	5.5	12.0	8.0	6.0	5.0	14.0	5.5	—	4.0
Blepharoplasty	8.0	10.0	12.0	8.0	9.0	6.0	14.0	13.0	10.0	4.0
Rhinoplasty	10.0	11.0	18.0	8.0	8.0	8.0	14.0	13.0	—	4.0
Scar Revision	12.0	12.0	20.0	17.0	12.0	9.5	14.0	16.0	10.0	4.0
Hand Surgery	6.0	12.0	15.0	6.5	5.8	6.0	9.0	11.0	10.0	4.0
Craniofacial Procedures	8.0	8.0	32.0	4.0	7.0	9.0	12.0	21.5	—	4.0
Skin Cancer and other Tumors	3.0	2.0	5.5	3.0	4.0	4.0	3.0	2.5	10.0	2.0
Weighted Median	9.9	10.7	18.1	10.0	8.8	7.1	12.8	12.2	10.0	5.3

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

Table 9b: Gynaecology (2004)—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	4.5	4.0	3.5	4.0	5.0	4.0	4.0	2.0
Tubal Ligation	8.0	7.0	12.0	6.0	5.0	8.0	7.0	5.0	8.0	4.0
Hysterectomy (Vaginal/Abdominal)	6.0	7.0	12.0	5.0	6.0	7.5	7.0	4.5	6.0	4.0
Vaginal Repair	8.0	8.0	13.0	5.0	6.0	8.0	6.0	6.0	6.0	4.0
Tuboplasty	8.0	8.0	17.0	9.5	6.0	8.0	9.0	5.0	—	6.0
Laparoscopic Procedures	5.0	6.0	10.0	4.0	5.0	6.0	5.0	5.0	9.0	4.0
Hysteroscopic Procedures	4.0	6.0	8.0	5.0	4.0	6.0	4.0	4.0	9.0	2.0
Weighted Median	5.5	5.6	9.5	5.4	4.7	6.0	5.8	4.6	6.8	3.1

Table 9c: Ophthalmology (2004)—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	9.0	8.0	10.0	8.0	9.0	12.0	6.0
Cornea Transplant	10.0	8.0	26.0	14.0	8.0	13.0	5.0	—	26.0	12.0
Cornea—Pterygium	7.5	8.0	7.0	4.0	8.0	10.0	8.0	12.0	12.0	9.0
Iris, Ciliary Body, Sclera, Anterior Chamber	8.0	6.0	10.5	6.0	4.0	5.0	7.0	4.0	—	12.0
Retina, Choroid, Vitreous	3.5	6.0	2.5	6.0	3.0	2.0	1.0	5.0	—	0.0
Lacrimal Duct	10.0	8.0	6.0	6.0	7.0	12.0	8.0	—	—	6.0
Strabismus	6.0	8.0	10.5	6.0	8.0	12.0	8.0	7.0	12.0	10.0
Operations on Eyelids	8.0	6.0	6.0	5.0	6.0	10.0	8.0	6.8	12.0	16.0
Glaucoma	4.0	4.0	3.3	5.0	4.0	3.5	4.0	3.0	12.0	5.0
Weighted Median	7.2	7.2	10.6	7.4	6.6	9.6	7.5	7.7	12.0	6.5

Note: Weighted median does not include treatment for glaucoma.

Table 9d: Otolaryngology (2004)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Myringotomy	4.0	2.8	4.0	3.5	4.0	4.0	6.0	4.0	—	2.0
Tympanoplasty	8.0	4.5	18.0	5.0	6.0	7.5	8.0	8.5	—	3.0
Thyroid, Parathyroid, and Other Endocrine Glands	5.0	4.0	8.0	12.0	5.0	4.0	4.0	12.0	—	3.0
Tonsillectomy and/or Adenoidectomy	8.0	5.5	18.0	8.0	6.0	6.0	8.0	6.0	—	3.0
Rhinoplasty and/or Septal Surgery	11.0	8.0	18.0	8.0	7.0	7.0	8.0	5.0	—	8.0
Operations on Nasal Sinuses	7.0	6.0	18.0	8.0	6.0	5.0	6.0	5.0	—	4.0
Weighted Median	7.0	4.7	12.2	6.5	5.3	4.7	7.0	5.7	—	3.0

Table 9e: General Surgery (2004)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Hernia/Hydrocele	6.0	6.0	12.0	5.0	4.0	6.0	8.0	5.5	4.5	4.8
Cholecystectomy	6.0	5.5	12.0	4.0	4.0	4.0	4.0	4.0	3.5	4.5
Colonoscopy	4.0	4.0	4.0	3.5	4.0	4.0	4.0	4.0	4.0	3.0
Intestinal Operations	3.5	4.0	4.0	3.0	3.0	4.0	4.0	2.0	4.0	2.3
Haemorrhoidectomy	6.0	6.0	12.0	4.0	5.0	4.0	8.0	6.0	5.0	5.0
Breast Biopsy	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	1.8
Mastectomy	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.5	2.0
Bronchus and Lung	2.0	4.0	3.0	3.0	3.0	2.0	2.0	—	3.0	—
Aneurysm Surgery	3.0	2.5	2.0	3.0	4.0	4.0	4.0	1.0	—	2.0
Varicose Veins	12.0	8.0	24.0	14.0	8.0	8.0	11.0	7.0	10.0	4.5
Weighted Median	4.3	4.5	7.0	3.7	3.6	4.0	4.4	3.5	3.9	3.3

Table 9f: Neurosurgery (2004)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Peripheral Nerve	4.5	5.0	8.0	4.0	5.5	4.0	9.0	4.0	—	—
Disc Surgery/ Laminectomy	5.0	6.0	5.5	—	4.0	4.0	11.0	3.0	—	—
Elective Cranial Bone Flap	4.0	3.0	6.0	1.0	4.0	3.0	5.5	4.0	—	—
Aneurysm Surgery	2.5	6.0	8.0	—	4.0	4.0	7.0	4.0	—	—
Carotid endarterectomy	2.0	2.0	6.0	—	2.0	3.0	4.5	2.0	—	—
Weighted Median	4.2	4.1	6.0	1.9	4.2	3.6	7.9	3.7	—	—

Table 9g: Orthopaedic Surgery (2004)—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	4.8	6.0	6.0	6.0	6.0	4.0	6.0	5.5	4.0
Removal of Pins	6.0	6.0	12.0	8.0	8.0	12.0	6.0	9.0	5.5	4.0
Arthroplasty (Hip, Knee, Ankle, Shoulder)	10.0	12.0	15.0	13.0	12.0	11.0	10.0	14.0	13.5	12.0
Arthroplasty (Interphalangeal, Metatarsophalangeal)	8.0	6.0	12.0	10.5	12.0	10.0	8.0	12.0	12.5	8.0
Hallux Valgus/Hammer Toe	8.0	7.0	20.0	9.0	8.0	12.0	8.0	12.0	5.5	10.0
Digit Neuroma	6.0	6.0	12.0	8.0	8.0	12.0	8.0	8.0	5.5	4.0
Rotator Cuff Repair	6.0	6.5	7.0	7.0	6.0	6.0	6.0	9.0	6.5	12.0
Ostectomy (All Types)	7.0	9.0	12.0	12.0	8.0	11.0	8.0	12.0	20.0	8.0
Routine Spinal Instability	8.0	12.0	12.0	9.0	8.0	11.0	12.0	10.0	16.0	11.0
Weighted Median	8.0	9.0	12.5	10.4	9.6	10.2	8.1	11.0	10.7	8.2

Table 9h: Cardiovascular Surgery (2004)—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	0.3	0.5	0.0	0.0	0.0	0.0	0.6	—	0.5
	Valves & Septa of the Heart	0.0	0.0	0.5	0.0	0.0	0.0	0.0	1.0	—	0.5
	Aneurysm Surgery	0.0	0.3	0.5	0.0	0.0	0.0	0.0	0.0	—	0.5
	Carotid Endarterectomy	0.4	0.5	0.3	0.0	0.0	0.0	0.2	0.0	—	0.5
	Pacemaker Operations	0.0	0.2	0.5	—	0.0	0.0	0.0	0.2	—	—
	Weighted Median	0.0	0.2	0.5	0.0	0.0	0.0	0.0	0.4	—	0.5
Urgent	Coronary Artery Bypass	1.5	1.0	2.0	2.0	1.0	0.5	2.0	2.5	—	1.5
	Valves & Septa of the Heart	1.0	1.0	2.0	2.0	1.0	0.5	2.0	3.3	—	1.5
	Aneurysm Surgery	1.0	2.3	2.0	1.8	1.0	0.2	2.0	1.0	—	0.5
	Carotid Endarterectomy	1.5	2.0	1.3	2.0	1.0	0.5	2.0	1.0	—	0.5
	Pacemaker Operations	0.8	0.5	2.0	—	1.0	0.0	1.0	1.0	—	—
	Weighted Median	1.0	0.8	2.0	2.0	1.0	0.3	1.5	2.0	—	1.4
Elective	Coronary Artery Bypass	8.0	8.0	10.0	12.0	5.0	4.0	6.0	9.0	—	12.0
	Valves & Septa of the Heart	8.0	8.0	10.0	12.0	5.0	4.0	6.0	12.0	—	12.0
	Aneurysm Surgery	4.0	4.5	6.0	8.5	4.8	4.0	4.0	4.0	—	2.5
	Carotid Endarterectomy	4.0	4.0	6.0	5.0	4.8	4.0	4.0	2.0	—	2.5
	Pacemaker Operations	4.5	4.0	6.0	—	4.0	2.0	6.0	4.0	—	—
	Weighted Median	5.9	6.1	8.2	11.5	4.6	3.3	5.9	7.2	—	11.4

Table 9i: Urology (2004)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Non-radical Prostatectomy	4.0	4.0	12.0	3.8	4.0	6.0	12.0	4.0	6.0	8.0
Radical Prostatectomy	2.0	4.0	3.5	3.0	4.0	4.0	6.0	5.0	4.0	4.0
Transurethral Resection—Bladder	2.0	2.0	2.0	3.5	3.0	3.0	4.0	3.5	3.0	2.0
Radical Cystectomy	2.0	4.0	2.0	3.5	3.0	2.0	4.0	4.0	4.0	2.0
Cystoscopy	2.0	2.0	2.0	3.0	2.0	3.0	8.0	3.0	0.0	4.0
Hernia/Hydrocele	6.0	4.0	20.0	6.0	6.0	10.0	8.0	6.0	10.0	12.0
Bladder Fulguration	2.0	2.3	3.5	4.0	2.8	2.0	4.0	4.0	0.0	4.0
Ureteral Reimplantation for Reflux	5.0	6.0	12.0	4.0	6.0	4.0	10.0	6.0	—	12.0
Weighted Median	2.6	2.3	4.0	3.5	2.5	3.3	7.6	3.4	2.2	4.5

Table 9j: Internal Medicine (2004)—Median Reasonable Wait for Treatment after Appointment with Specialist (in Weeks)

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Colonoscopy	2.0	4.0	4.0	2.0	3.0	4.0	2.5	4.0	8.0	3.0
Angiography/ Angioplasty	2.0	2.3	1.8	2.5	2.3	2.3	6.0	3.3	4.0	4.0
Bronchoscopy	2.0	2.0	1.0	1.5	2.0	2.0	3.0	2.3	3.5	2.0
Gastroscopy	2.0	4.0	1.8	2.0	2.5	2.5	2.0	4.0	3.0	3.0
Weighted Median	2.0	3.7	3.2	2.0	2.8	3.5	2.8	3.8	7.1	3.1

Table 9k: Radiation Oncology (2004)—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	7.0	3.0	2.0	2.0	2.8	2.5	1.0	2.0
Cancer of the Cervix	—	3.0	7.0	3.0	2.0	2.0	2.5	1.3	1.0	2.0
Lung Cancer	2.0	3.0	—	4.0	2.0	2.0	3.0	2.8	—	2.0
Prostate Cancer	—	3.5	—	8.0	4.0	6.0	4.0	4.0	3.0	5.0
Breast Cancer	—	4.0	—	4.0	2.5	4.0	4.5	3.0	4.0	3.5
Early Side Effects from Treatment	0.5	1.0	0.0	0.0	1.0	1.0	0.5	0.5	1.0	0.5
Late Side Effects from Treatment	2.0	2.0	1.0	1.0	1.0	1.0	2.0	1.0	1.0	2.0
Weighted Median	2.0	3.5	7.0	5.1	2.8	3.6	3.7	3.2	3.3	3.6

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

Table 9l: Medical Oncology (2004)—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	1.5	—	4.0	2.0
Cancer of the Cervix	2.0	3.0	—	—	2.3	2.0	1.5	2.0	4.0	—
Lung Cancer	2.0	1.8	—	—	2.0	1.8	1.5	1.0	4.0	2.0
Breast Cancer	2.0	2.0	—	—	2.0	1.8	1.5	4.0	3.0	5.0
Side Effects from Treatment	0.0	0.0	—	—	0.5	0.0	0.5	0.0	0.1	0.5
Weighted Median	2.0	1.9	—	—	2.0	1.8	1.5	2.4	3.6	3.7

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 Specialty, 2004

	British Columbia			Alberta			Saskatchewan			Manitoba			Ontario		
	A	R	D	A	R	D	A	R	D	A	R	D	A	R	D
Plastic Surgery	22.8	9.9	130%	18.2	10.7	70%	59.7	18.1	230%	23.7	10.0	137%	14.4	8.8	63%
Gynaecology	8.6	5.5	57%	7.1	5.6	27%	13.6	9.5	44%	7.3	5.4	36%	6.1	4.7	30%
Ophthalmology	12.0	7.2	66%	8.1	7.2	12%	30.5	10.6	189%	9.8	7.4	32%	17.1	6.6	160%
Otolaryngology	16.7	7.0	139%	7.5	4.7	62%	55.8	12.2	358%	5.8	6.5	-11%	10.0	5.3	89%
General Surgery	7.6	4.3	75%	4.9	4.5	9%	13.4	7.0	92%	4.5	3.7	21%	4.7	3.6	29%
Neurosurgery	8.3	4.2	96%	6.3	4.1	54%	12.5	6.0	107%	2.5	1.9	31%	8.8	4.2	111%
Orthopaedic Surgery	32.2	8.0	305%	24.1	9.0	168%	75.2	12.5	501%	18.4	10.4	76%	18.0	9.6	88%
Cardiovascular Surgery (Urgent)	1.9	1.0	86%	3.1	0.8	272%	2.0	2.0	-1%	1.0	2.0	-49%	1.0	1.0	2%
Cardiovascular Surgery (Elective)	13.3	5.9	126%	8.0	6.1	31%	12.4	8.2	51%	8.6	11.5	-25%	4.2	4.6	-7%
Urology	6.9	2.6	167%	3.4	2.3	51%	13.3	4.0	229%	6.4	3.5	80%	3.6	2.5	41%
Internal Medicine	6.3	2.0	217%	10.5	3.7	186%	6.5	3.2	101%	3.1	2.0	56%	5.4	2.8	94%
Radiation Oncology	1.5	2.0	-25%	5.0	3.5	44%	3.1	7.0	-56%	2.8	5.1	-46%	6.0	2.8	117%
Medical Oncology	1.5	2.0	-24%	4.2	1.9	115%	—	—	—	—	—	—	2.5	2.0	24%
Weighted Median	11.6	5.0	132%	8.3	5.0	67%	24.5	7.8	212%	7.8	5.5	43%	8.2	4.6	81%

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 Specialty, 2004

	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	16.0	7.1	125%	22.8	12.8	78%	34.5	12.2	183%	22.3	10.0	123%	45.2	5.3	759%
Gynaecology	6.1	6.0	1%	6.0	5.8	3%	6.7	4.6	47%	9.6	6.8	41%	4.5	3.1	45%
Ophthalmology	15.3	9.6	59%	10.7	7.5	43%	9.7	7.7	25%	20.2	12.0	68%	7.5	6.5	16%
Otolaryngology	5.8	4.7	24%	8.3	7.0	17%	6.8	5.7	20%	—	—	—	6.2	3.0	106%
General Surgery	5.4	4.0	36%	4.7	4.4	6%	4.2	3.5	20%	11.9	3.9	203%	4.9	3.3	52%
Neurosurgery	6.7	3.6	87%	25.1	7.9	217%	5.1	3.7	38%	—	—	—	4.1	—	—
Orthopaedic Surgery	20.8	10.2	104%	20.9	8.1	157%	30.9	11.0	181%	41.0	10.7	282%	16.9	8.2	106%
Cardiovascular Surgery (Urgent)	0.8	0.3	150%	3.1	1.5	115%	2.2	2.0	14%	—	—	—	1.4	1.4	0%
Cardiovascular Surgery (Elective)	4.1	3.3	26%	8.5	5.9	43%	7.8	7.2	8%	—	—	—	58.6	11.4	413%
Urology	6.5	3.3	97%	21.6	7.6	185%	5.8	3.4	67%	3.0	2.2	37%	9.1	4.5	102%
Internal Medicine	5.4	3.5	57%	8.2	2.8	187%	5.7	3.8	50%	15.8	7.1	123%	7.6	3.1	148%
Radiation Oncology	8.5	3.6	137%	10.6	3.7	184%	2.9	3.2	-10%	8.1	3.3	145%	6.2	3.6	72%
Medical Oncology	1.3	1.8	-28%	1.5	1.5	0%	1.5	2.4	-39%	2.6	3.6	-28%	6.2	3.7	67%
Weighted Median	9.2	5.8	59%	10.9	5.8	88%	8.9	5.3	68%	15.7	6.2	154%	8.9	4.2	111%

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, 2004

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CAN
Plastic Surgery	0.4%	0.3%	0.1%	2.0%	0.7%	0.6%	0.0%	0.3%	0.0%	0.0%	0.6%
Gynaecology	1.3%	0.7%	1.6%	1.9%	1.1%	0.5%	0.0%	0.8%	0.0%	0.0%	0.9%
Ophthalmology	1.1%	1.0%	0.7%	0.0%	1.2%	0.3%	0.9%	0.7%	0.0%	0.2%	0.9%
Otolaryngology	1.0%	1.4%	0.3%	0.7%	1.8%	0.7%	14.5%	0.0%	—	0.0%	1.7%
General Surgery	3.1%	0.7%	0.6%	0.1%	1.1%	0.3%	1.0%	0.6%	0.9%	0.9%	1.1%
Neurosurgery	1.0%	0.3%	1.4%	5.0%	3.2%	0.0%	0.0%	0.2%	—	0.0%	1.4%
Orthopaedic Surgery	1.8%	1.3%	0.7%	0.9%	1.2%	0.8%	0.1%	1.5%	0.5%	1.8%	1.2%
Cardiovascular Surgery	1.1%	0.9%	1.6%	0.3%	1.2%	0.4%	0.2%	0.3%	—	—	0.9%
Urology	2.2%	2.2%	0.5%	2.5%	1.5%	0.5%	2.8%	0.5%	—	0.2%	1.5%
Internal Medicine	2.6%	2.0%	1.1%	1.7%	1.5%	1.0%	0.3%	0.1%	1.0%	0.3%	1.5%
Radiation Oncology	0.0%	0.8%	1.0%	1.0%	1.5%	0.5%	3.8%	0.0%	—	1.0%	1.2%
Medical Oncology	1.2%	0.7%	—	—	2.6%	1.5%	3.0%	1.5%	0.0%	1.0%	1.8%
All Specialties	1.7%	1.1%	0.9%	1.3%	1.3%	0.6%	2.1%	0.6%	0.5%	0.5%	1.2%

Table 12: Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist, by Specialty, 2004.

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Plastic Surgery	3,267	1,758	2,200	1,286	6,389	3,836	1,332	1,172	111	810
Gynaecology	4,724	3,519	2,047	2,231	9,992	5,408	1,074	970	178	397
Ophthalmology	11,386	4,623	9,420	1,633	52,203	70,991	961	2,492	266	546
Otolaryngology	4,509	1,787	4,963	764	11,634	3,524	1,512	630	—	393
General Surgery	8,177	4,850	5,116	1,784	19,758	16,714	2,297	1,366	632	978
Neurosurgery	741	512	335	72	2,801	1,497	480	111	—	65
Orthopaedic Surgery	19,026	10,083	13,203	3,701	31,713	16,358	2,685	4,547	853	984
Cardiovascular Surgery	372	350	79	28	517	340	126	112	—	22
Urology	5,667	2,369	3,574	1,005	12,145	15,053	7,239	1,763	68	1,198
Internal Medicine	3,682	5,828	1,478	661	12,516	10,587	2,066	1,080	415	847
Radiation Oncology	23	38	18	9	139	378	29	15	0	6
Medical Oncology	59	313	—	—	1,067	387	43	23	4	204
Residual	39,260	26,749	26,550	10,213	110,355	71,130	11,435	11,064	1,566	5,022
Total	100,895	62,777	68,984 ¹	23,386	271,230	216,204	31,278	25,344	4,093	11,471
Proportion of Population	2.43%	1.99%	6.93%	2.01%	2.22%	2.89%	4.16%	2.71%	2.97%	2.21%
Canada:	Total number of procedures for which patients are waiting in 2004								815,663	
	Percentage of Population								2.58%	

Note: Totals may not match sums of numbers for individual procedures 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 24,024 patients on wait lists for non-emergent surgery in Regina and Saskatoon at March 31, 2004. For an extensive explanation, please refer to "Verification of current data with governments—Saskatchewan."

Table 13a: Plastic Surgery (2004)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Mammoplasty	1,781	936	795	570	2,789	1,838	486	546	34	257
Neurolysis	222	297	64	102	1,438	772	157	63	61	278
Blepharoplasty	50	86	26	26	297	95	83	25	1	11
Rhinoplasty	492	122	871	105	528	314	213	116	0	71
Scar Revision	462	136	130	282	519	378	211	334	7	128
Hand Surgery	260	182	314	202	818	440	181	89	9	65
Total	3,267 ¹	1,758 ²	2,200	1,286	6,389	3,836	1,332	1,172	111	810

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

¹BC Ministry of Health web site reports 4,918 patients waiting for plastic surgery at April 30, 2004.

²Alberta Health and Wellness web site reports 1,889 patients waiting for non-emergent plastic surgery at 11 facilities across the province at June 30, 2004.

Table 13b: Gynaecology (2004)—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	750	1,158	69	268	1,805	1,099	249	134	14	94
Tubal Ligation	1,067	635	424	1,277	2,074	459	267	196	31	69
Hysterectomy (Vaginal/Abdominal)	1,464	665	823	283	2,644	1,698	274	334	97	123
Vaginal Repair	237	156	210	55	584	435	56	86	10	30
Tuboplasty	46	27	40	19	44	49	6	8	0	2
Laparoscopic Procedures	416	332	242	117	1,260	692	86	92	13	20
Hysteroscopic Procedures	744	546	239	210	1,581	976	136	119	13	58
Total	4,724 ¹	3,519 ²	2,047	2,231	9,992	5,408	1,074	970	178	397

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

¹BC Ministry of Health web site reports 5,823 patients waiting for gynecological surgery at April 30, 2004.

²Alberta Health and Wellness web site reports 3,811 patients waiting for non-emergent gynecological surgery at 19 facilities across the province at June 30, 2004.

Table 13c: Ophthalmology (2004)—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	8,906 ¹	3,274	8,527	1,088	43,740	66,246 ³	696	2,018	242	356
Cornea Transplant	412 ¹	54	36	126	694	568	23	—	4	6
Cornea—Pterygium	84	63	34	21	475	275	9	13	3	12
Iris, Ciliary Body, Sclera, Anterior Chamber	287	265	416	—	2,151	1,050	28	75	—	10
Retina, Choroid, Vitreous	823	662	81	292	2,384	619	11	191	—	52
Lacrimal Duct	181	86	123	22	525	859	85	51	—	29
Strabismus	284	44	99	—	1,595	780	20	96	2	22
Operations on Eyelids	408	174	104	83	639	594	90	48	15	58
Total	11,386¹	4,623²	9,420	1,633	52,203	70,991	961	2,492	266	546

Notes: 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 15,821 patients waiting for ophthalmology, 14,308 waiting for cataract surgery, and 626 waiting for cornea transplant at April 30, 2004.

²Alberta Health and Wellness web site reports 2,643 patients waiting for non-emergent eye surgery at 14 facilities across the province, and 1,899 waiting for non-emergent cataract surgery at 13 facilities at June 30, 2004.

³Quebec Ministry of Health and Social Services web site reports 17,859 patients waiting for cataract treatment in June and July 2004.

Table 13d: Otolaryngology (2004)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Myringotomy	643	286	159	215	2,931	1,702	433	123	—	67
Tympanoplasty	341	32	630	19	428	272	129	61	—	14
Thyroid, Parathyroid, and Other Endocrine Glands	391	151	307	112	1,173	382	29	44	—	44
Tonsillectomy and/or Adenoidectomy	1,359	1,009	2,387	295	4,858	321	668	257	—	221
Rhinoplasty and/or Septal Surgery	753	41	525	57	546	284	98	58	—	10
Operations on Nasal Sinuses	1,022	268	955	67	1,698	562	155	86	—	37
Total	4,509¹	1,787²	4,963	764	11,634	3,524	1,512	630	—	393

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

¹BC Ministry of Health web site reports 5,160 patients waiting for ear, nose, and throat surgery at April 30, 2004.

²Alberta Health and Wellness web site reports 2,595 patients waiting for non-emergent ear, nose, and throat surgery at 12 facilities across the province at June 30, 2004.

Table 13e: General Surgery (2004)—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	1,980	852	1,655	313	2,934	1,971	261	315	89	163
Cholecystectomy	1,212	788	1,340	209	2,101	1,594	290	329	70	200
Colonoscopy	2,600	1,302	559	486	7,521	9,028	1,122	275	367	389
Intestinal Operations	1,172	1,156	569	354	4,754	2,467	382	256	67	138
Haemorrhoidectomy	468	270	672	119	915	673	110	61	10	31
Breast Biopsy	42	31	23	13	113	70	19	49	1	7
Mastectomy	437	209	93	119	705	436	56	65	18	28
Bronchus and Lung	102	29	11	50	261	125	12	—	1	1
Aneurysm Surgery	24	4	3	5	42	38	4	0	—	0
Varicose Veins	140	209	190	116	413	311	42	15	10	20
Total	8,177¹	4,850²	5,116	1,784	19,758	16,714	2,297	1,366	632	978

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

¹BC Ministry of Health web site reports 12,958 patients waiting for general surgery at April 30, 2004.

²Alberta Health and Wellness web site reports 4,880 patients waiting for non-emergent general surgery at 21 facilities across the province at June 30, 2004.

Table 13f: Neurosurgery (2004)—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	89	85	18	20	571	137	35	12	—	29
Disc Surgery/ Laminectomy	342	223	181	27	1,210	953	347	37	—	24
Elective Cranial Bone Flap	277	196	127	23	981	343	90	60	—	12
Aneurysm Surgery	3	3	1	0	8	6	1	1	—	0
Carotid endarterectomy	31	5	7	2	30	57	7	1	—	—
Total	741¹	512²	335	72	2,801	1,497	480	111	—	65

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

¹BC Ministry of Health web site reports 1,274 patients waiting for neurosurgery at April 30, 2004.

²Alberta Health and Wellness web site reports 363 patients waiting for non-emergent neurosurgery at 4 facilities across the province at June 30, 2004.

Table 13g: Orthopaedic Surgery (2004)—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	1,428	720	624	138	2,582	1,535	151	255	115	61
Removal of Pins	1,081	472	919	182	1,928	1,404	166	155	33	111
Arthroplasty (Hip, Knee, Ankle, Shoulder)	13,204 ¹	7,038 ²	9,268	2,404	19,718	7,411 ³	1,501	2,998	574	574
Arthroplasty (Interphalangeal, Metatarsophalangeal)	268	137	123	45	690	406	63	90	14	12
Hallux Valgus/Hammer Toe	143	19	206	43	448	161	40	39	13	25
Digit Neuroma	589	505	680	482	2,025	2,418	267	200	44	51
Rotator Cuff Repair	549	415	252	101	1,740	1,063	114	282	39	66
Ostectomy (All Types)	973	502	561	239	1,709	1,426	289	385	20	70
Routine Spinal Instability	792	275	571	66	874	535	94	143	0	14
Total	19,026¹	10,083²	13,203	3,701	31,713	16,358	2,685	4,547	853	984

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

¹BC Ministry of Health web site reports 18,871 patients waiting for orthopaedic surgery, 2,842 waiting for hip surgery, and 4,843 waiting for knee surgery at April 30, 2004.

²Alberta Health and Wellness web site reports 7,746 patients waiting for non-emergent orthopaedic surgery at 16 facilities across the province, 1,501 waiting for hip replacement at 12 facilities, and 2,685 waiting for knee replacement at 12 facilities at June 30, 2004.

³Quebec Ministry of Health and Social Services web site reports 1,754 patients waiting for arthroplasty of the hip and 3,092 patients waiting for arthroplasty of the knee in June and July 2004.

Table 13h: Cardiovascular Surgery (2004)—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	193	197 ²	33	13	185	200	61	40	—	18
Valves & Septa of the Heart	66	69	11	7	85	40	23	24	—	4
Aneurysm Surgery	2	1	0	0	3	1	0	1	—	0
Carotid Endarterectomy	18	8	2	8	24	18	3	5	—	0
Pacemaker Operations	94	74	32	—	220	82	38	43	—	—
Total	372¹	350²	79	28	517	340³	126	112	—	22

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

¹BC Ministry of Health web site reports 409 patients waiting for cardiac surgery and 1,241 waiting for vascular surgery at April 30, 2004.

²Alberta Health and Wellness web site reports 467 patients waiting for non-emergent cardiac surgery at 2 facilities across the province, 504 waiting for non-emergent vascular surgery at 6 facilities, 241 waiting for non-emergent thoracic surgery at 3 facilities, and 186 waiting for non-emergent coronary artery bypass surgery at 2 facilities at June 30, 2004.

³Quebec Ministry of Health and Social Services reports 469 adults waiting for cardiac surgery in March 2004.

Table 13i: Urology (2004)—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	838	194	1,255	78	1,020	946	220	111	24	70
Radical Prostatectomy	98	56	14	13	311	145	35	30	11	9
Transurethral Resection—Bladder	329	121	58	34	702	461	121	52	6	23
Radical Cystectomy	17	9	3	2	52	17	6	6	1	2
Cystoscopy	2,925	1,503	363	561	7,372	11,202	5,905 ³	1,300	0	993
Hernia/Hydrocele	908	256	1,720	126	1,393	1,664	543	143	25	54
Bladder Fulguration	531	223	128	188	1,256	598	389	115	0	44
Ureteral Reimplantation for Reflux	21	6	34	3	39	20	21	5	—	3
Total	5,667¹	2,369²	3,574	1,005	12,145	15,053	7,239	1,763	68	1,198

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

¹BC Ministry of Health web site reports 5,954 patients waiting for urological surgery at April 30, 2004.

²Alberta Health and Wellness web site reports 1,727 patients waiting for non-emergent urological surgery at 14 facilities across the province at June 30, 2004.

³New Brunswick Health and Wellness reports 1,435 patients waiting for cystoscopy in March 2004, an increase of 17% over March 2003.

Table 13j: Internal Medicine (2004)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Colonoscopy	2,211	4,988	983	507	9,888	8,168	1,341	843	336	472
Angiography /Angioplasty	1,245	407	328	86	1,101	951	663	129	38	241
Bronchoscopy	87	93	30	9	518	769	13	49	19	19
Gastroscopy	139	341	137	59	1,009	698	50	59	22	116
Total	3,682	5,828	1,478	661	12,516	10,587	2,066	1,080	415	847

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

Table 13k: Radiation Oncology (2004)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Radiotherapy	23 ¹	38	18	9	139	378	29	15	0	6

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 237 patients waiting for radiotherapy at April 22, 2004.

Table 13l: Medical Oncology (2004)—Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Chemotherapy	59	313	—	—	1,067	387	43	23	4	204

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 (2004)—Procedures per 100,000 Population

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Plastic Surgery	79	56	221	111	52	51	177	125	81	156
Gynaecology	114	112	206	192	82	72	143	104	129	76
Ophthalmology	275	147	947	140	427	948	128	266	193	105
Otolaryngology	109	57	499	66	95	47	201	67	—	76
General Surgery	197	154	514	153	161	223	306	146	458	188
Neurosurgery	18	16	34	6	23	20	64	12	—	12
Orthopaedic Surgery	459	320	1,327	318	259	218	357	486	618	189
Cardiovascular Surgery	9	11	8	2	4	5	17	12	—	4
Urology	137	75	359	86	99	201	964	188	49	230
Internal Medicine	89	185	148	57	102	141	275	115	301	163
Radiation Oncology	1	1	2	1	1	5	4	2	0	1
Medical Oncology	1	10	—	—	9	5	6	2	3	39

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, 2003 and 2004¹

	British Columbia			Alberta			Saskatchewan			Manitoba			Ontario		
	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg
Plastic Surgery	3,267	4,423	-26%	1,758	1,678	5%	2,200	1,523	44%	1,286	1,471	-13%	6,389	5,513	16%
Gynaecology	4,724	5,220	-9%	3,519	4,312	-18%	2,047	3,296	-38%	2,231	2,572	-13%	9,992	11,198	-11%
Ophthalmology	11,386	8,907	28%	4,623	3,478	33%	9,420	9,194	2%	1,633	1,718	-5%	52,203	40,989	27%
Otolaryngology	4,509	4,939	-9%	1,787	3,011	-41%	4,963	6,441	-23%	764	1,371	-44%	11,634	10,910	7%
General Surgery	8,177	8,027	2%	4,850	5,290	-8%	5,116	5,346	-4%	1,784	1,955	-9%	19,758	18,728	5%
Neurosurgery	741	892	-17%	512	524	-2%	335	225	49%	72	—	—	2,801	2,574	9%
Orthopaedic Surgery	19,026	18,158	5%	10,083	9,479	6%	13,203	14,332	-8%	3,701	3,380	9%	31,713	32,176	-1%
Cardiovascular Surgery	372	703	-47%	350	1,660	-79%	79	152	-48%	28	81	-65%	517	723	-28%
Urology	5,667	5,749	-1%	2,369	3,040	-22%	3,574	3,518	2%	1,005	598	68%	12,145	12,590	-4%
Internal Medicine	3,682	4,993	-26%	5,828	4,233	38%	1,478	2,022	-27%	661	831	-21%	12,516	10,594	18%
Radiation Oncology	23	24	-2%	38	163	-77%	18	28	-35%	9	46	-80%	139	295	-53%
Medical Oncology	59	79	-25%	313	288	9%	—	—	—	—	—	—	1,067	1,213	-12%
Residual	39,260	47,683	-18%	26,749	30,925	-14%	26,550	31,553	-16%	10,213	12,803	-20%	110,355	110,251	0%
Total	100,895	109,796	-8%	62,777	68,082	-8%	68,984	77,628	-11%	23,386	26,828	-13%	271,230	257,755	5%

¹The 2004 figures are based on procedures counts classified by the recently introduced ICD-10/CCI data standard. Figures published in the 13th edition of *Waiting Your Turn* were based on the older ICD-9/CCP standard. For this reason, the numbers of procedures for which patients are waiting are not directly comparable with the previously published numbers because of a much more accurate counting of procedures that is possible under the new data standard. Previous estimates of procedures for which patients are waiting have been presented in this edition of *Waiting Your Turn*, but the changes between 2003 and 2004 should be interpreted with caution.

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.

continued ...

Table 15: Comparison of Estimated Number of Procedures for which Patients are Waiting after Appointment with Specialist, by Selected Specialties, 2003 and 2004¹

	Quebec			New Brunswick			Nova Scotia			Prince Edward Island			Newfoundland		
	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg
Plastic Surgery	3,836	5,655	-32%	1,332	786	69%	1,172	2,299	-49%	111	—	—	810	988	-18%
Gynaecology	5,408	7,565	-29%	1,074	1,525	-30%	970	907	7%	178	128	39%	397	623	-36%
Ophthalmology	70,991	82,691	-14%	961	1,864	-48%	2,492	2,467	1%	266	360	-26%	546	464	17%
Otolaryngology	3,524	7,973	-56%	1,512	1,273	19%	630	802	-21%	—	—	—	393	1,004	-61%
General Surgery	16,714	19,682	-15%	2,297	980	134%	1,366	1,767	-23%	632	509	24%	978	912	7%
Neurosurgery	1,497	1,696	-12%	480	354	35%	111	68	63%	—	—	—	65	27	139%
Orthopaedic Surgery	16,358	16,067	2%	2,685	2,157	24%	4,547	5,991	-24%	853	429	99%	984	696	41%
Cardiovascular Surgery	340	443	-23%	126	52	143%	112	223	-50%	—	—	—	22	27	-20%
Urology	15,053	19,100	-21%	7,239	2,279	218%	1,763	1,546	14%	68	114	-40%	1,198	818	46%
Internal Medicine	10,587	9,246	14%	2,066	626	230%	1,080	1,096	-1%	415	384	8%	847	647	31%
Radiation Oncology	378	302	25%	29	46	-38%	15	32	-53%	0	—	—	6	8	-26%
Medical Oncology	387	610	-37%	43	79	-46%	23	123	-81%	4	4	18%	204	108	89%
Residual	71,130	97,748	-27%	11,435	8,913	28%	11,064	14,923	-26%	1,566	1,393	12%	5,022	4,892	3%
Total	216,204	268,780	-20%	31,278	20,935	49%	25,344	32,245	-21%	4,093	3,320	23%	11,471	11,215	2%

¹The 2004 figures are based on procedures counts classified by the recently introduced ICD-10/CCI data standard. Figures published in the 13th edition of *Waiting Your Turn* were based on the older ICD-9/CCP standard. For this reason, the numbers of procedures for which patients are waiting are not directly comparable with the previously published numbers because of a much more accurate counting of procedures that is possible under the new data standard. Previous estimates of procedures for which patients are waiting have been presented in this edition of *Waiting Your Turn*, but the changes between 2003 and 2004 should be interpreted with caution.

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, 2002-03 (Part I)

Procedure	BC	AB	SK	ON	NS	PE	NL
Arthroplasty (Hip, Knee, Ankle, Shoulder)	8,696	7,134	2,832	28,739	2,474	297	827
Arthroplasty (Interphalangeal/Metatarsophalangeal)	537	414	96	1,002	84	4	54
Hallux Valgus/Hammer Toe	149	94	29	461	27	1	13
Meniscectomy/Arthroscopy	217	263	182	911	42	8	50
Ostectomy	1,728	1,973	482	4,865	517	25	157
Removal of Pins	957	982	240	2,793	182	15	86
Rotator Cuff Repair	588	606	190	1,642	173	19	80
Routine Spinal Instability	792	915	280	2,838	308	0	71
Bladder Fulguration	1,262	1,269	1,078	5,395	491	55	256
Cystoscopy	2,635	1,789	992	10,672	1,524	125	852
Non-radical Prostatectomy	3,489	1,468	910	8,325	919	127	298
Radical Cystectomy	148	99	29	453	54	7	22
Radical Prostatectomy	847	666	185	2,691	195	70	113
Transurethral Resection—Bladder	1,102	714	460	4,882	256	51	249
Ureteral Reimplantation for Reflux	83	152	35	249	26	2	8
Cataract Removal	296	301	110	659	78	10	48
Cornea Transplant	66	105	34	45	19	2	21
Cornea—Pterygium	11	8	4	8	4	0	1
Iris, Ciliary Body, Sclera, Anterior Chamber	337	325	101	544	142	5	30
Lacrimal Duct Surgery	50	67	73	106	23	0	32
Operations on Eyelids	166	161	79	546	92	4	26
Retina, Choroid, Vitreous	2,246	4,275	527	4,887	481	0	324
Strabismus Surgery	14	18	69	114	5	1	2
Myringotomy	306	332	98	1,024	137	28	152
Operations on Nasal Sinuses	464	837	76	1,502	309	59	192
Thyroid, Parathyroid, and Other Endocrine Glands	1,237	1,384	353	5,571	319	20	197
Tonsillectomy and/or Adenoidectomy	1,573	1,665	1,121	3,637	570	218	870
Tympanoplasty	137	123	12	524	125	4	27
Radiotherapy	566	311	255	951	269	1	52
Chemotherapy	1,943	1,960	607	10,181	784	80	431
Breast Biopsy	118	71	45	305	23	3	29
Bronchus and Lung	846	667	193	3,265	348	24	97

Source: Canadian Institute for Health Information, "All Procedures Performed," listed by CCI code, 2002-03; and Fiscal 2004/05 CCI to CCP Conversion Tables.

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

Table 16a: Acute Inpatient Procedures, 2002-03 (Part II)

Procedure	BC	AB	SK	ON	NS	PE	NL
Cholecystectomy	4,575	4,303	2,319	10,604	1,591	360	1
Haemorrhoidectomy	139	134	76	410	24	11	26
Intestinal Operations	6,802	5,338	2,041	20,880	2,281	308	1,085
Mastectomy	2,815	2,227	773	6,001	744	100	360
Varicose Veins	90	270	117	278	44	22	52
Disk Surgery/Laminectomy	1,464	1,399	386	5,925	303	8	186
Elective Cranial Bone Flap	2,361	2,302	815	7,196	619	0	395
Blepharoplasty	5	8	7	78	9	1	1
Mammoplasty	1,117	756	295	3,346	110	31	124
Scar Revision	877	1,157	182	1,457	225	16	92
Coronary Artery Bypass	2,503	2,035	863	9,638	1,033	0	620
Pacemaker Operations	4,570	1,812	606	8,650	689	61	702
Valves & Septa of the Heart	1,674	1,403	291	4,364	421	0	125
Angiography/Angioplasty	3,881	2,573	1,706	7,934	788	56	764
Bronchoscopy	669	1,477	210	3,979	364	15	241
Gastroscopy	553	1,045	274	3,914	285	30	263
Dilation and Curettage	571	488	116	1,491	40	17	102
Hysterectomy	6,338	4,705	1,719	17,117	1,924	315	1,067
Hysteroscopic Procedures	189	201	64	629	35	5	31
Laparoscopic Procedures	930	575	214	2,526	155	13	86
Tubal Ligation	1,624	1,414	828	4,381	479	105	270
Tuboplasty	105	77	26	137	9	5	7
Vaginal Repair	644	630	229	2,547	336	15	211
Rhinoplasty and/or Septal Surgery	372	246	32	746	263	31	95
Hernia/Hydrocele	4,736	4,030	2,309	20,890	1,658	303	880
Carotid Endarterectomy	730	319	129	1,227	69	46	70
Hand Surgery/Digit Neuroma	339	380	92	1,062	69	5	60
Neurolysis/Peripheral Nerve	387	392	139	3,038	104	22	58
Colonoscopy	2,741	2,745	1,373	10,906	771	165	740
Aneurysm Surgery	208	196	49	592	68	0	9
Residual	84,490	81,371	24,955	278,390	26,485	2,141	13
Total	172,105	157,156	55,012	550,120	52,995	5,472	28

Source: Canadian Institute for Health Information, "All Procedures Performed," listed by CCI code, 2002-03; and Fiscal 2004/05 CCI to CCP Conversion Tables

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

Table 16b: Same Day Procedures, 2002-03 (Part I)

Procedure	BC	SK	ON	NS	PE	NL
Arthroplasty (Hip, Knee, Ankle, Shoulder)	4,508	1,802	13,983	644	306	239
Arthroplasty (Interphalangeal/Metatarsophalangeal)	535	133	1,240	156	17	54
Hallux Valgus/Hammer Toe	316	74	1,481	142	21	45
Meniscectomy/Arthroscopy	4,423	1,066	10,276	1,064	192	481
Ostectomy	802	229	2,542	225	18	69
Removal of Pins	2,555	495	5,560	392	43	203
Rotator Cuff Repair	997	314	4,390	361	39	166
Routine Spinal Instability	0	0	1	1	0	0
Bladder Fulguration	3,340	581	10,928	1,005	25	312
Cystoscopy	22,712	8,458	117,107	9,743	581	4
Non-radical Prostatectomy	871	22	517	43	0	5
Transurethral Resection—Bladder	2,318	294	4,248	425	16	52
Ureteral Reimplantation for Reflux	1	0	2	21	0	1
Cataract Removal	34,656	12,207	98,231	8,665	619	2
Cornea Transplant	376	2	880	128	0	0
Cornea—Pterygium	424	143	1,537	64	9	75
Iris, Ciliary Body, Sclera, Anterior Chamber	908	597	13,436	839	21	49
Lacrimal Duct Surgery	736	193	3,309	197	3	39
Operations on Eyelids	1,602	600	4,993	324	34	310
Retina, Choroid, Vitreous	6,315	1,150	26,103	1,999	9	128
Strabismus Surgery	1,217	176	3,075	451	5	94
Myringotomy	2,876	1,556	18,025	1,686	245	1,005
Operations on Nasal Sinuses	2,194	476	7,326	252	37	364
Thyroid, Parathyroid, and Other Endocrine Glands	33	23	531	11	0	3
Tonsillectomy and/or Adenoidectomy	2,845	258	17,416	767	66	177
Tympanoplasty	750	352	1,702	272	9	175
Radiotherapy	236	50	251	2	0	0
Chemotherapy	96	206	12,189	25,5	1	274
Breast Biopsy	617	398	2,055	995	16	222
Bronchus and Lung	40	4	122	31	0	1
Cholecystectomy	3,305	585	16,704	1,262	42	427
Haemorrhoidectomy	1,888	844	7,518	432	51	202

Source: Canadian Institute for Health Information, "All Procedures Performed," listed by CCI code, 2002-03; and Fiscal 2004/05 CCI to CCP Conversion Tables.

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

Table 16b: Same Day Procedures, 2002-03 (Part II)

Procedure	BC	SK	ON	NS	PE	NL
Intestinal Operations	8,432	2,891	40,918	2,161	325	1,309
Mastectomy	4,752	1,163	12,339	952	235	614
Varicose Veins	719	249	3,299	151	32	26
Disk Surgery/Laminectomy	17	7	365	18	0	0
Elective Cranial Bone Flap	37	10	94	9	0	5
Blepharoplasty	158	106	1,467	45	2	16
Mammoplasty	1,607	145	3,906	236	3	23
Scar Revision	324	59	793	232	6	36
Pacemaker Operations	1,038	236	2,777	424	7	159
Valves & Septa of the Heart	42	7	52	2	0	0
Angiography/Angioplasty	4,209	1,134	6,378	330	61	163
Bronchoscopy	620	74	2,760	363	26	253
Gastroscopy	1,056	616	9,204	476	85	595
Dilation and Curettage	7,226	1,681	21,976	1,513	161	1
Hysterectomy	6	64	72	6	0	3
Hysteroscopic Procedures	4,650	1,319	13,075	993	100	771
Laparoscopic Procedures	1,773	414	6,833	645	89	173
Tubal Ligation	3,924	1,009	13,591	1,222	128	628
Tuboplasty	134	24	150	24	4	8
Vaginal Repair	383	113	1,248	113	19	52
Rhinoplasty and/or Septal Surgery	2,539	743	4,529	364	10	89
Hernia/Hydrocele	8,556	1,895	21,696	2,313	289	885
Carotid Endarterectomy	1	0	2	0	0	0
Hand Surgery/Digit Neuroma	3,708	1,002	11,259	1,180	97	497
Neurolysis/Peripheral Nerve	1,037	217	5,669	326	153	641
Colonoscopy	27,691	11,339	139,968	10,108	1,691	5
Aneurysm Surgery	1	1	7	1	0	0
Residual	91,794	30,760	410,211	37,676	3,054	19
Total	280,926	90,566	1,142,316	94,507	9,006	46

Source: Canadian Institute for Health Information, "All Procedures Performed," listed by CCI code, 2002-03; and Fiscal 2004/05 CCI to CCP Conversion Tables.

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

Appendix 1: Psychiatry Waiting List Survey (2nd Edition)

Over the last few years, 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 reporters have also come to The Fraser Institute searching for information about waiting times for this medical specialty. Such data is typically not available from local or regional governments and, where it is available, is not comparable across jurisdictions. We have responded to this absence by adding Psychiatry to the annual measurement of waiting lists reported in *Waiting Your Turn*.

As this is only the second year that this data is being presented, readers should interpret the survey results below with caution. Though the authors are confident about the actual survey responses, the survey methodology and the methodology by which the final median scores for psychiatry are calculated are still being developed and may be revised over the next few years. For this same reason, this year's Psychiatry survey results have been placed in an appendix to *Waiting Your Turn* rather than included in the main body of the text.

Despite these caveats, the authors feel it is important to present the numbers from the second annual survey of psychiatrists. Information on the performance of the health care system is rare in Canada, and patients with mental health concerns want the same access to information that is available for those with physical ailments in both *Waiting Your Turn* and through some provinces' provincial health ministries.

Methodology

The psychiatry waiting list survey was conducted between January and March 2004. 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 Ottawa (214 specialists, 107 surveyed), Hamilton (95, 48 surveyed), Toronto (620, 310 surveyed), London (96, 48 surveyed), and North York (87, 44 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 are sent French-language surveys. The response rate to the psychiatry survey was 22 percent overall, an increase of 1 percent from 2003, and ranged from 35 percent in New Brunswick to 17 percent in Quebec (table A1).

The treatments identified in the following tables represent a cross-section of common procedures 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.

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

Table A1: Summary of Responses

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	Can
Mailed	518	262	42	135	1,093	924	31	105	6	37	3,153
Number of Responses	117	68	14	27	259	158	11	29	2	8	693
Response Rates	23%	26%	33%	20%	24%	17%	35%	28%	33%	22%	22%

Table A2: Psychiatry (2004)—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	2.0	2.0	2.0	2.0	1.8	2.0	1.0	1.5	2.0
Elective	9.0	9.0	12.0	6.0	7.5	6.0	20.0	10.0	8.0	6.0	7.6

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 2003 and 2004.

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 psychologists, 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 methodology 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 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.⁷

Survey results: estimated waiting in Canada

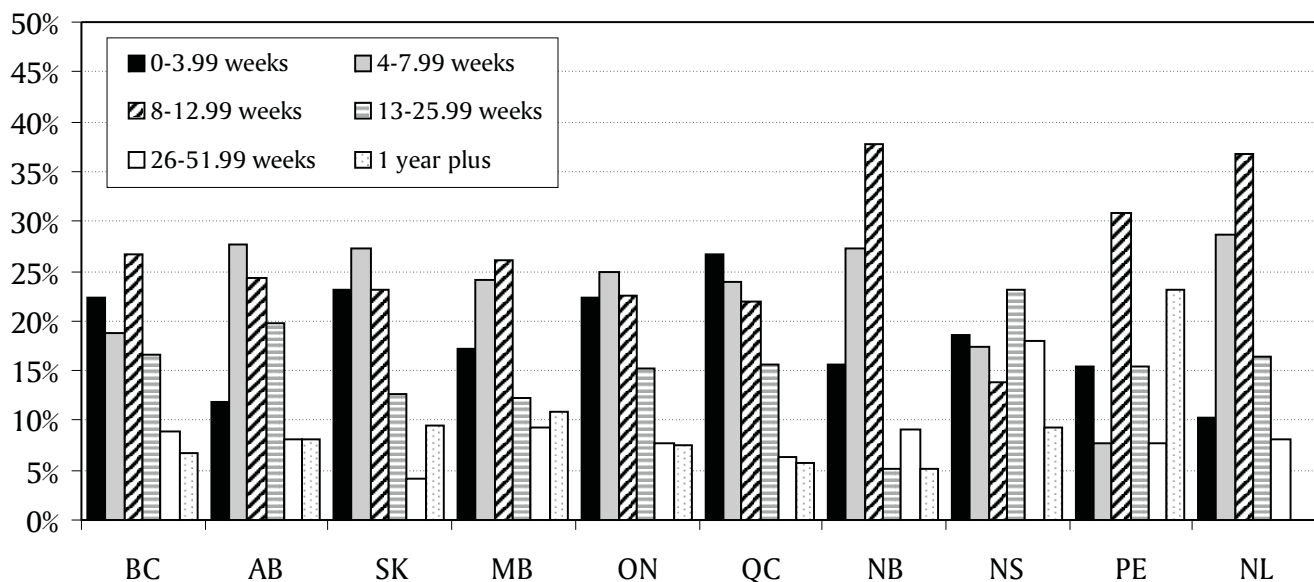
The total waiting time for psychiatric treatment is composed of two segments: waiting after being referred by a general practitioner before consultation with a psychiatrist, and subsequently, waiting to receive treatment after the first consultation with a psychiatrist. The 2004 psychiatry survey provides 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 2.0 weeks, both for Canada as a whole and in most provinces. The waiting time for referrals on an elective basis for Canada as a whole was 7.6 weeks. The longest waiting times for elective referrals was in New Brunswick (20.0 weeks), followed by Sas-

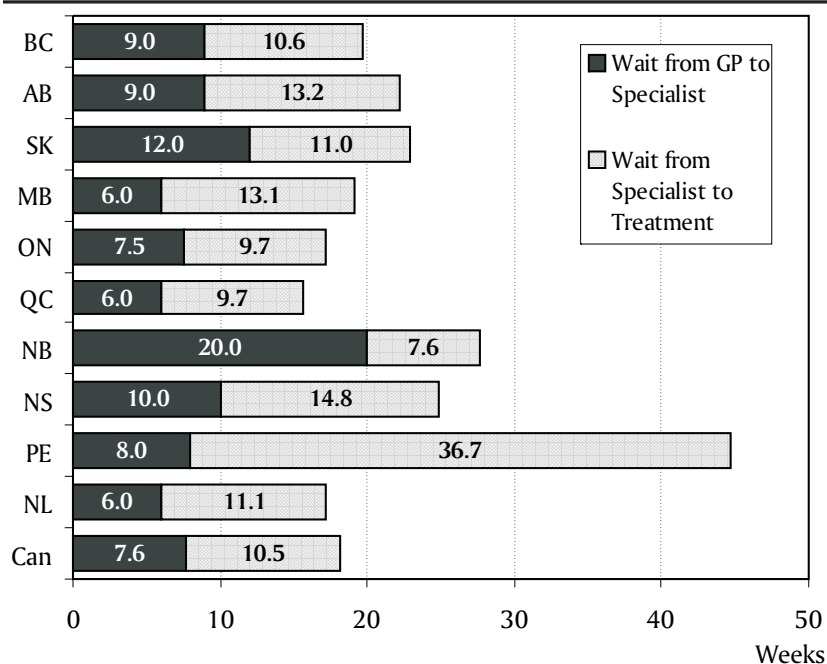
7 For comparison, the overall Canadian median waiting time for CT Scans was 5.2 weeks in the traditional 12 specialties and 5.8 weeks in the psychiatry survey, with a mean absolute difference (the average of absolute differences between the two measures) of 1.6 for 9 provinces (PEI was not included in this measure due to the small sample). The overall Canadian median waiting time for magnetic resonance imaging in the psychiatry survey was 14.9 weeks, compared to 12.6 weeks for the other 12 specialties. The mean absolute difference in this case, again for 9 provinces, was 3.2 weeks.

Table A3: Psychiatry (2004)—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	8.0	6.5	10.0	7.0	6.0	6.0	8.0	11.0	10.0	8.0	6.7
Initiate a course of long-term psychotherapy	12.0	11.0	16.0	12.0	12.0	12.0	11.0	11.0	100.0	17.0	12.2
Initiate a course of pharmacotherapy	5.0	4.0	3.5	4.5	4.0	3.3	7.3	4.0	5.8	6.0	4.0
Initiate a course of couple/marital therapy	8.0	7.0	10.0	9.5	8.0	8.0	6.0	11.5	8.3	9.0	8.1
Initiate cognitive behaviour therapy	8.0	9.5	8.0	10.0	10.0	9.0	8.0	11.0	6.0	7.5	9.3
Access a day program	8.0	8.5	4.0	4.5	5.0	4.0	6.5	15.0	—	8.0	5.8
Access an eating disorders program	16.0	12.0	5.0	12.0	13.0	20.0	7.0	14.0	14.0	9.0	15.2
Access a housing program	18.0	23.0	4.0	14.0	24.0	9.0	8.0	16.0	150.0	12.0	17.5
Access an evening program	6.0	10.0	8.0	4.0	8.0	9.0	7.0	7.8	12.0	8.0	7.9
Access a sleep disorders program	24.0	48.0	48.0	52.0	5.0	20.0	8.0	50.0	51.0	24.0	20.5
Access assertive community treatment or similar program	4.0	6.0	4.0	14.5	12.0	6.0	7.0	12.0	10.0	14.0	8.4
Unweighted Median	10.6	13.2	11.0	13.1	9.7	9.7	7.6	14.8	36.7	11.1	10.5

Graph A1: Frequency Distribution of Survey Waiting Times (Specialist to Treatment) by Province 2004

**Graph A2: Median Wait by Province in 2004:
Weeks Waited from Referral by GP to Treatment**



katchewan (12.0 weeks), and Nova Scotia (10.0 weeks). The shortest wait for an elective referral was in Manitoba, Quebec, and Newfoundland (6.0 weeks), followed by Ontario (7.5 weeks), and Prince Edward Island (8.0 weeks).

forms the highest proportion of treatments within 13 weeks (80.5 percent) while Saskatchewan and Quebec perform the highest proportion within 8 weeks (50.5%). Waits of 26 weeks or more are least frequent in Newfoundland (8.2%) and most frequent in Prince Edward Island (30.8%).

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 Prince Edward Island (36.7 weeks), Nova Scotia (14.8 weeks), and Alberta (13.2 weeks), while the shortest waits were found in New Brunswick (7.6 weeks), Quebec, and Ontario (9.7 weeks), and British Columbia (10.6 weeks). Among the treatments, patients waited longest to access a sleep disorders program (20.5 weeks) or a housing program (17.5 weeks), while the wait times were shortest for pharmacotherapy (4.0 weeks), and accessing a day program (5.8 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. New Brunswick per-

Table A4i: Comparison of Median Weeks Waited to Receive Treatment after Appointment with Specialist, by Province, 2003 and 2004

	British Columbia			Alberta			Saskatchewan			Manitoba			Ontario		
	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg
Psychiatry	10.6	10.7	0%	13.2	12.3	8%	11.0	12.2	-10%	13.1	12.4	6%	9.7	9.5	3%

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, 2003 and 2004

	Quebec			New Brunswick			Nova Scotia			Prince Edward Island			Newfoundland		
	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg	2004	2003	% chg
Psychiatry	9.7	10.0	-3%	7.6	19.6	-61%	14.8	12.5	19%	36.7	27.1	35%	11.1	7.6	47%

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 (2004)—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	4.0	4.0	3.8	4.0	4.0	4.0	3.5	4.0	—	2.0	4.0
Initiate a course of long-term psychotherapy	6.0	5.0	6.0	6.0	6.0	6.0	4.0	6.0	—	8.0	5.9
Initiate a course of pharmacotherapy	2.0	2.0	1.0	2.0	2.0	2.0	2.0	2.0	—	2.0	2.0
Initiate a course of couple/marital therapy	4.0	4.0	4.0	4.0	4.0	4.0	5.0	6.0	—	3.0	4.1
Initiate cognitive behaviour therapy	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.5	—	2.5	4.0
Access a day program	3.0	4.0	2.3	2.5	2.5	3.0	2.5	5.0	—	4.0	3.0
Access an eating disorders program	4.0	4.0	3.0	4.0	4.0	4.0	4.0	5.0	3.0	4.0	4.0
Access a housing program	4.0	4.0	3.3	4.0	4.0	4.0	4.0	5.0	—	2.0	4.0
Access an evening program	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.8	—	2.0	4.0
Access a sleep disorders program	6.0	6.0	6.0	8.0	4.0	5.0	4.0	8.0	—	4.0	5.1
Access assertive community treatment or similar program	2.0	4.0	3.5	5.0	4.0	3.0	3.5	2.0	—	4.0	3.3
Unweighted Median	3.9	4.1	3.7	4.3	3.9	3.9	3.7	4.8	3.0	3.4	3.9

Table A4 compares the 2003 and 2004 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 (0.4%), Saskatchewan (10%), Quebec (3%), and New Brunswick (61%). At the same time, between 2003 and 2004, the median wait increased by 8 percent in Alberta, 6 percent in Manitoba, 3 percent in Ontario, 19 percent in Nova Scotia, 35 percent in Prince Edward Island, and 47 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 2003 was 18.1 weeks for Psychiatry (Graph A2), a 4 percent decrease from the 18.8 weeks measured in 2003. The shortest

waiting times were recorded in Quebec (15.7 weeks), Newfoundland (17.1 weeks), and Ontario (17.2 weeks). The longest total waits were found in Prince Edward Island (44.7 weeks), New Brunswick (27.6 weeks), and Nova Scotia (24.8 weeks).

Finally, physicians responding to the survey are asked to provide a clinically reasonable waiting time for the various treatments. Specialists generally indicate 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. Of the actual median waiting times for treatments (in table A3), 99 percent are greater than the clinically reasonable median waiting times (in table A5). For the specialty of Psychiatry, New Brunswick 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 107 and 147 percent, respectively, smaller

Table A6: Psychiatry (2004)—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%	63%	167%	75%	50%	50%	129%	175%	—	300%	68%
Initiate a course of long-term psychotherapy	100%	120%	167%	100%	100%	100%	175%	83%	—	113%	105%
Initiate a course of pharmacotherapy	150%	100%	250%	125%	100%	63%	263%	100%	—	200%	102%
Initiate a course of couple/marital therapy	100%	75%	150%	138%	100%	100%	20%	92%	—	200%	100%
Initiate cognitive behaviour therapy	100%	138%	100%	150%	150%	125%	100%	144%	—	200%	132%
Access a day program	167%	113%	78%	80%	100%	33%	160%	200%	—	100%	98%
Access an eating disorders program	300%	200%	67%	200%	225%	400%	75%	180%	367%	125%	279%
Access a housing program	350%	475%	23%	250%	500%	125%	100%	220%	—	500%	338%
Access an evening program	50%	150%	100%	0%	100%	125%	75%	63%	—	300%	99%
Access a sleep disorders program	300%	700%	700%	550%	25%	300%	100%	525%	—	500%	301%
Access assertive community treatment or similar program	100%	50%	14%	190%	200%	100%	100%	500%	—	250%	151%
Unweighted Median	172%	223%	196%	203%	152%	147%	107%	212%	1,123%	227%	167%

gaps than in the other provinces. The differences between the median reasonable and median 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 4.2 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 77.6 percent (Fraser Institute, national hospital waiting list survey, 2004).

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 2003, waiting times for both CT and MRI scans increased in 2004, while the waiting time for an EEG was unchanged. The median wait for a CT scan across Canada was 5.8 weeks, ranging from a high of 9.5 weeks (Manitoba), to a low of 1.0 weeks (Prince Edward Island). The median wait for an MRI across Canada was 14.9 weeks. Saskatchewan patients waited the longest (38.0 weeks), while patients in New Brunswick waited the least amount of time (9.0 weeks). Finally, the median wait for an EEG across Canada was 3.8 weeks. Residents of Prince Edward Island faced the shortest waits for an EEG (1.0 weeks), while residents of Manitoba waited longest (5.0 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 times nearing 5 months from a general practitioner to

Table A7: Waiting for Technology 2004: Weeks Mental Health Patients Waited to Receive Selected Diagnostic Tests

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

treatment, and with wait times from a meeting with a specialist to treatment that are nearly 3 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.

Gastroscopy: 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.hlth.gov.bc.ca/waitlist/
- 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/
- Cardiac Care Network of Ontario
www.ccn.on.ca/access.html
- Cancer Care Ontario
www.cancercare.on.ca/access_waitTimes.htm
- Quebec Ministry of Health and Social Services
www.msss.gouv.qc.ca/sujets/listesdattente/index.html