

Priority Areas for Wait Time Reduction: What We Know and What We Don't Know

Tracy Johnson, Kathleen Morris and Jennifer Zelmer

Reducing wait times for surgery and other health services is a prominent policy issue in Canada and many other countries. Governments' plans to improve access and reduce wait times include a range of strategies, one of which is to increase the number of surgeries performed. Proponents say that this is an important way to reduce the number of patients waiting for care. Others have questioned whether it is possible to increase the number of procedures in a limited number of priority areas without crowding out other types of care.

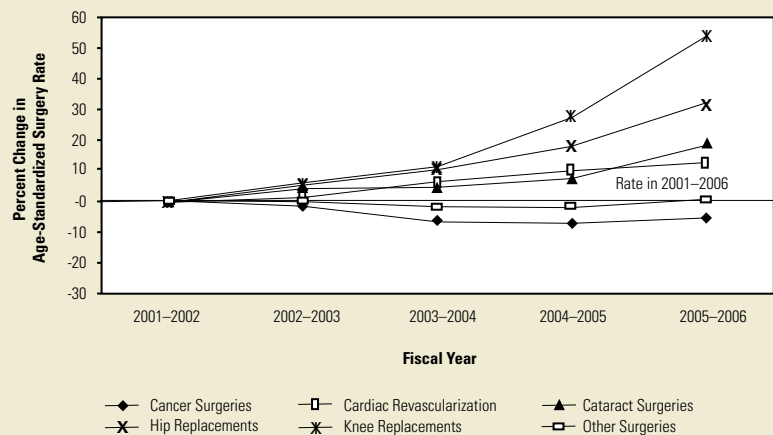
In the recent study *Surgical Volume Trends within and beyond Wait Time Priority Areas* (Canadian Institute for Health Information [CIHI] 2007a), CIHI explored trends in the numbers of people who receive surgeries that fall within first ministers' wait time priority areas (cancer, heart, joint replacement and sight-restoration procedures), as well as trends in the numbers of people who have surgery for other health problems. The study tracked the rates of in-patient and day surgery procedures performed in Canada outside of Quebec between 2001–2002 and 2005–2006. The priority areas for wait time reductions were identified by Canada's first ministers in the fall of 2004 (Canadian Intergovernmental Conference Secretariat 2007).

Nearly 42,000 additional procedures in wait time priority areas were performed in Canada outside Quebec in 2005–2006 compared with the previous year. This represents an annual increase of 7%, after adjusting for population growth and aging, in the combined total number of procedures in all four surgical wait time priority areas. The increase is largely due to a surge in the number of hip and knee replacements and cataract surgeries. Surgical rates for cardiac revascularization and cancer also saw modest growth between 2004–2005 and 2005–2006 (Figure 1).

While we know that there has been a significant increase in priority area surgeries, a key question is what effect these additional surgeries are (or are not) having on waits for care.

While thousands of patients receive priority area procedures every year, they account for less than one-fifth of all surgeries performed annually. In 2005–2006, more than two million Canadians outside of Quebec had procedures for conditions (other than pregnancy or trauma) that were outside the wait time priority areas. The rate of surgeries outside priority areas increased by 2% over the same period, after taking population growth and aging into account.

Figure 1. Trends in age-standardized surgery rates, 2001–2002 to 2005–2006*



*Excludes Quebec. Total surgical procedures exclude those for trauma, pregnancy and child-birth, newborns and mental health. Includes only qualifying day procedures.

Sources: Discharge Abstract Database, National Ambulatory Care Reporting System, CIHI; special tabulations provided by Alberta Health and Wellness and Manitoba Health.

Variations in Surgical Trends

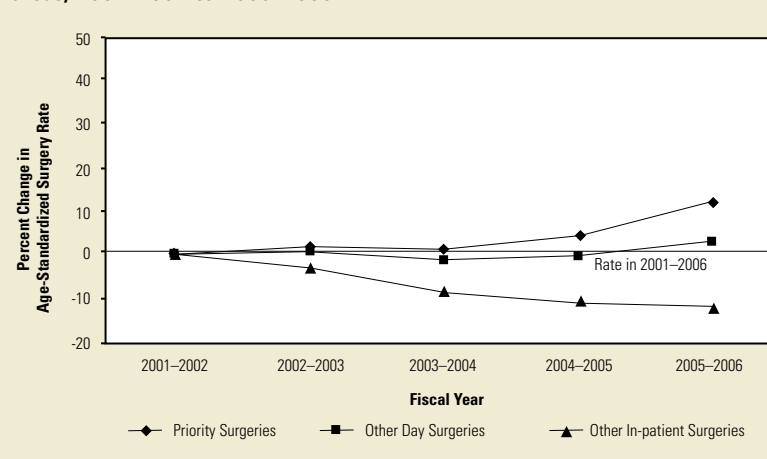
The objective of the CIHI study was to provide a first look at the overall picture of surgical volumes within and outside of priority areas, but there may be variations in these trends by region, hospital, type of surgeon or type of surgery. The study took a preliminary look at three potential sources of variation: surgical setting, province and selected clinical programs:

1. Surgical setting. Overall, the number of surgical cases outside of the four priority areas increased during the past year (2004–2005 to 2005–2006) by 4%, or 2% after adjusting for population growth and aging (Figure 2). Within this overall trend, there were important shifts from in-patient to day surgery. Virtually all of the growth came from an increased number of day surgery cases.
2. Provincial trends. Between 2004–2005 and 2005–2006, the overall rate of surgery beyond the wait time priority areas was maintained or increased in all jurisdictions, even after population growth and aging were considered (Figure 3). That said, the rate at which procedures (both within and outside of priority areas) grew varied by jurisdiction. For example, while Manitoba and Ontario had similar growth rates for priority procedures overall, numbers of specific types of surgery grew at different rates. Almost two-thirds (63%) of Ontario's increase came from increased rates of cataract surgery, while in Manitoba over half (56%) of the change was from growth in joint replacements.
3. Clinical programs. While overall surgical rates outside of the wait time priority areas grew between 2004–2005 and 2005–2006, there was some variation by type of surgery. For example, rates of orthopedic surgery other than hip and knee replacements, and cardiac surgery other than revascularization procedures, grew at about the same pace as the population. However, the number of eye procedures performed other than cataract surgery grew almost 3% after adjusting for population growth and aging.

Comparing Trends over Five Years

The growth rate in priority area surgeries in 2005–2006 was higher than the average in recent years. The average increase

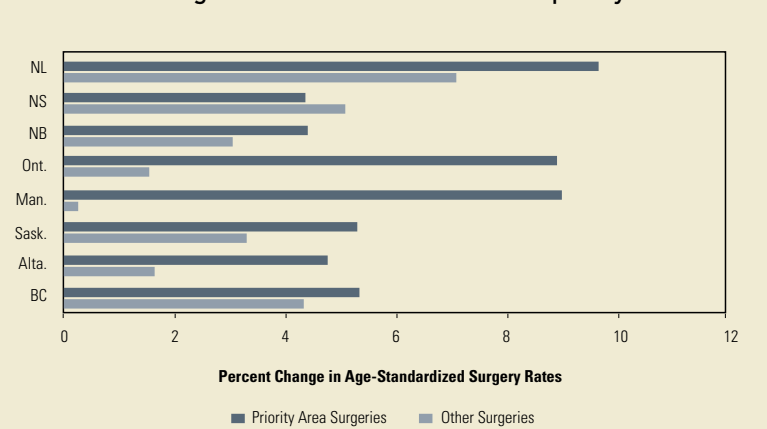
Figure 2. Trends in procedure rates within and outside of wait time priority areas, 2001–2002 to 2005–2006*



*Excludes Quebec. Total surgical procedures exclude those for trauma, pregnancy and child-birth, newborns and mental health. Includes only qualifying day procedures.

Sources: Discharge Abstract Database, National Ambulatory Care Reporting System, CIHI; special tabulations provided by Alberta Health and Wellness and Manitoba Health.

Figure 3. Percent growth in standardized rates between 2004–2005 and 2005–2006 for surgeries within and outside wait time priority areas*



*Excludes Quebec. Total surgical procedures exclude those for trauma, pregnancy and child-birth, newborns and mental health. Includes only qualifying day procedures.

Sources: Discharge Abstract Database, National Ambulatory Care Reporting System, CIHI; special tabulations provided by Alberta Health and Wellness and Manitoba Health.

in rates of surgery within wait time priority areas was 1% per year from 2001–2002 to 2004–2005, compared with 7% in 2005–2006. All percentage changes are adjusted for population growth and aging.

Other key findings include the following:

- Hip replacement surgery rates rose by 12% in 2005–2006 over the previous year, while knee replacement surgery rates grew almost twice as fast, increasing by 20% over the same period. Although surgical rates for both types of joint replacement have increased every year since 2001–2002, over 40% of the growth occurred in 2005–2006.
- Cataract surgery increased by 10% in 2005–2006. More than 23,000 additional surgeries were performed in 2005–2006 than in the previous year.
- Cardiac revascularization procedure rates grew in each of the past five years, increasing by 12% overall. However, trends for specific procedures vary within this category. For example, cardiac bypass rates are down, while angioplasty rates are growing. This reflects international trends in cardiac care.
- Cancer surgery rates rose slightly in 2005–2006 (up 2%) after falling in the four previous years (between 2001–2002 and 2004–2005). There are a number of possible explanations for this trend (e.g., changes in the location of care, the use of alternatives to surgery and flat trends in the number of new cancer cases), although their relative importance is not well understood.

While we know that there has been a significant increase in priority area surgeries, a key question is what effect these additional surgeries are (or are not) having on waits for care. A recent assessment of wait times reported on provincial websites concluded that we do not yet have enough comparable data to track trends in how long Canadians are waiting for surgery (CIHI 2007b). *Wait Times Tables—A Comparison by Province, 2007* updated information on wait times reported for cardiac procedures, cancer treatment, cataract procedures, diagnostic imaging and joint replacements (five areas identified as priorities by the first ministers) and first surveyed by CIHI in December 2005.

Systematic tracking of wait times is still a relatively new activity in many parts of the country. Compared to one year ago, the study found both the breadth and the depth of wait time information have improved, but information gaps remain. Variations in definitions, summary measures, time periods reported and time elapsed between data collection and reporting continue to make pan-Canadian comparisons and assessment of how wait times might have changed over time challenging.

HQ

References

Canadian Institute for Health Information. 2007a. *Analysis in Brief: Surgical Volume Trends within and beyond Wait Times Priority Areas*. Ottawa: Author.

Canadian Institute for Health Information. 2007b. *Analysis in Brief: Wait Times Tables – A Comparison by Province, 2007*. Ottawa: Author

Canadian Intergovernmental Conference Secretariat. 2007. *A 10-Year Plan to Strengthen Health Care*. Ottawa: Author. Retrieved January 5, 2007. <http://www.scics.gc.ca/cinfo04/800042005_e.pdf>.

About the Authors

Tracy Johnson, MBA, is project consultant for CIHI. She recently joined CIHI to work specifically on reporting of wait times for health services. She has previous clinical and management experience working in both private and public sectors.

Kathleen Morris, MBA, conducts special projects for CIHI. Recent assignments have included coordinating CIHI activities regarding the measurement and reporting of wait times for health services, developing a long-range analytic plan and assessing how CIHI data and reports are used by decision-makers.

Jennifer Zelmer, PhD, is vice-president of Research and Analysis for CIHI. In this role, she leads an integrated program of health services and population health-related analytical and research initiatives. Prior to joining CIHI in 1995, she worked with a variety of health, academic and government organizations in Canada, Australia, Denmark and India, among other countries.

If you are NOT on our career site's directory,
 this is how many hits a month you're missing ...
 (translates to 350,000 pages read by your potential employees)

1.2 million

Contact Susan Hale at shale@longwoods.com



Register your healthcare recruitment site on www.healthcarejobsite.ca