

Waiting for Care in Canada: Findings from the Health Services Access Survey

Les temps d'attente pour obtenir des soins au Canada : constatations de l'Enquête sur l'accès aux services de santé



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Abstract

Waiting for care has been and continues to be a major issue for the healthcare sector in Canada. While considerable gains have been made regarding valid and reliable information on waiting times, gaps remain. Statistics Canada continues to provide information regarding patients' experiences in accessing care at the national and provincial levels, including how long individuals waited for specialized services, through the Health Services Access Survey. The survey offers several advantages, including waiting time information that is comparable across time and space, enhanced patient information and information regarding patients' experiences in waiting for care. The results for 2005 indicate that median waiting time for all specialized services was between 3 and 4 weeks and remained relatively stable between 2003 and 2005. Waiting times for specialist visits did not vary by income. In addition to being asked

how long they waited, individuals were asked about their experiences in waiting for care. While the majority of individuals waiting for care indicated that their waiting time was acceptable, there continues to be a proportion of Canadians who feel they are waiting an unacceptably long time for care. Between 11% and 18% of individuals waiting for care indicated that their life was affected by waiting.

Résumé

Les temps d'attente pour obtenir des soins ont été et continuent d'être un problème majeur dans le secteur de la santé au Canada. Bien que d'importants progrès aient été réalisés dans la compilation de données valides et fiables sur les temps d'attente, il existe encore des fossés considérables. Statistique Canada continue de publier des données sur le vécu des patients en matière d'accès aux soins aux échelons national et provincial – y compris les temps d'attente pour les services spécialisés – grâce à l'Enquête sur l'accès aux services de santé. L'Enquête offre plusieurs avantages, notamment des données sur les temps d'attente comparables dans le temps et dans l'espace, des données améliorées sur les patients et des données sur le vécu des patients qui attendent de recevoir des soins. Les résultats de 2005 indiquent que le temps d'attente médian pour tous les services spécialisés était de 3 à 4 semaines et qu'il est demeuré relativement stable entre 2003 et 2005. Les temps d'attente pour consulter des spécialistes n'ont pas varié selon le revenu. En plus de les interroger sur leur temps d'attente, on a demandé aux répondants de relater leur vécu pendant cette attente. Tandis que la majorité des patients qui attendaient de recevoir des soins ont indiqué que leur temps d'attente était acceptable, il y a un pourcentage de Canadiens qui sont encore d'avis qu'ils attendent beaucoup trop longtemps pour obtenir des soins. Entre 11 % et 18 % des personnes en attente de recevoir des soins ont indiqué que cette attente avait nui à leur vie.

WAITING FOR CARE HAS BEEN AND CONTINUES TO BE A MAJOR ISSUE for the healthcare sector in Canada. Since 2000, the Federal/Provincial/Territorial First Ministers have focused on reducing waits and improving access to care. In 2001, First Ministers agreed to report on a set of nationally comparable indicators to monitor the performance of the healthcare system, including waiting times for specialized services. In 2004, First Ministers agreed to develop a 10-year plan to improve access and reduce waiting times in several key areas, including hip and knee replacements and cataract surgery. The plan called for the establishment of benchmarks for medically acceptable waiting times, with regular reporting to track progress towards these targets (F/P/T First Ministers 2004; Ontario Ministry of Health 2005).

Information is a key component of the Federal/Provincial/Territorial initiatives. While considerable gains have been made at the provincial level to improve the state of information (BC Ministry of Health 2006; Alberta Health and Wellness 2006; Ontario Ministry of Health 2006; Nova Scotia Department of Health 2006), gaps continue to exist, including a lack of comparable information across jurisdictions as well as information on patients' experiences in waiting for care. The Health Services Access Survey (HSAS) was developed by Statistics Canada in 2001 to address several of these information gaps (Sanmartin et al. 2004). The HSAS was designed to capture information on patients' experiences in accessing care, including experiences related to waiting for specialized services such as specialist consultations, non-emergency surgery and diagnostic tests. The survey is conducted every two years and recently (2005) has been incorporated into the Canadian Community Health Survey.

The following report provides the latest results from the HSAS (2005), highlighting several key advantages of the survey, including wait time information that is comparable across time and space, enhanced patient information and key insights regarding patients' experiences in waiting for care.

Methods

Data

The report is based on a subsample of the 2005 Canadian Community Health Survey (CCHS). The CCHS represents approximately 98% of the population of Canadians aged 15 and older living in private dwellings in the 10 provinces. Excluded from this survey are residents of the three territories, those living on Indian reserves or Crown lands, residents in institutions, full-time members of the Canadian Forces and residents of certain remote regions. The data were collected by personal and telephone interviews between January and December 2005.

Since the respondents are a subsample of the CCHS, the same multiple sample frames of the parent survey apply. The CCHS uses the area frame designed for the Canadian Labour Force Survey (LFS). The sampling plan of the LFS is a multi-stage stratified cluster design in which the dwelling is the final sampling unit. The CCHS also uses two types of telephone frames: list frames and a random digit-dialing (RDD) sampling frame of telephone numbers.

In order to produce reliable estimates at the national and provincial levels, in particular for the estimates of waiting times, a subsample of about 34,000 CCHS respondents was targeted in total for 2005. The subsample was selected using a stratified random sampling technique. The total number of respondents was 33,539.

Analytical methods

Weighted distributions and frequencies were produced. Weighted median waiting times were calculated for specialist visits, non-emergency surgery and selected diagnostic tests. Partial or item non-responses accounted for less than 5% of the totals in most analyses; records with item non-responses were excluded from the calculations. The bootstrap technique was used to estimate the variance and confidence intervals to account properly for the complex survey design. This technique fully adjusts for the design effects of the survey. Confidence intervals were established at the level of $p=0.05$.

Results

Comparable waiting time data

One of the key advantages of the HSAS is the fact that the data are comparable across time and space. Recently, a review of provincial wait time registries highlighted the differences in the methods used to define, collect and report wait time information – differences that seriously compromise any efforts to compare wait time information across jurisdictions (CIHI 2006). In an effort to overcome this barrier, the HSAS was designed using a standard set of definitions and methods, thus ensuring a high degree of comparability. HSAS respondents were asked how long they had waited for care between the time that they and their healthcare provider agreed they needed the service (i.e., decision to treat) and the time that treatment was received. In the case of non-emergency surgery, for example, respondents were asked, “How long did you have to wait between when you and the surgeon decided to go ahead with surgery and the day of surgery?” Similar questions were used to collect information for specialist visits and diagnostic tests. The notion of waiting time, defined as “decision to treat” to “treatment,” was recently adopted by the Federal/Provincial/Territorial governments in relation to the wait time benchmarks established in December 2005.

Table 1 provides the latest results on median waiting times for specialized services by province. In 2005, the median waiting time was 4.3 weeks for specialist visits and non-emergency surgery and 3.0 weeks for diagnostic tests. The medians varied across provinces between 3.0 and 6.0 weeks for specialist visits, between 4.3 and 6.0 weeks for non-emergency surgery and between 2.0 and 4.3 weeks for diagnostic tests.

Nationally, median waiting times remained stable between 2003 and 2005, but there were some differences at the provincial level for selected specialized services. Median waiting times for non-emergency surgery were reduced by half in Quebec from almost 9 weeks in 2003 to 4 weeks in 2005 (Table 2). For diagnostic tests, median waiting times in Newfoundland rose significantly from 2 weeks in 2003 to 4 weeks in 2005, and in British Columbia median waits rose from 2 weeks to 3 weeks (data not shown).

TABLE 1. Median waiting times (weeks) for specialized services by province, Canada, 2005

	SPECIALIST VISIT		NON-EMERGENCY SURGERY		DIAGNOSTIC TESTS	
	ESTIMATE	95% C.I.	ESTIMATE	95% C.I.	ESTIMATE	95% C.I.
Newfoundland and Labrador	4.3	3.3, 5.3	4.3 ^E	2.8, 5.8	4.3	3.2, 5.4
Prince Edward Island	4.3	3.0, 5.6	4.3	3.3, 5.3	3.0 ^E	1.8, 4.2
Nova Scotia	4.0	2.9, 5.1	4.3	3.1, 5.4	2.0 ^E	0.9, 3.1
New Brunswick	4.3	3.3, 5.3	4.3	3.7, 4.9	3.0 ^E	1.5, 4.5
Quebec	3.0	2.2, 3.8	4.3 ^E	2.6, 6.0	2.0 ^E	1.0, 3.0
Ontario	4.3	4.0, 4.6	4.3	3.3, 5.3	3.0	2.2, 3.8
Manitoba	6.0 ^E	3.9, 8.1	6.0 ^E	3.2, 8.8	3.0 ^E	1.4, 4.6
Saskatchewan	4.3	3.7, 4.9	..	..	4.3	3.1, 5.5
Alberta	4.3	3.2, 5.3	4.3 ^E	2.2, 6.3	2.0	1.6, 2.4
British Columbia	4.3	3.9, 4.6	5.0	3.4, 6.6	3.0	2.3, 3.7
CANADA	4.3	4.0, 4.6	4.3	3.9, 4.7	3.0	2.3, 3.7

Notes: E - Interpret with caution (high variability)

.. - Data not provided due to extreme sampling variability or small sample size

Specialist waiting times by socio-economic status

A second advantage of the HSAS is the availability of a breadth of patient information, including demographic, socio-economic and health status information available in the CCHS that can be used to clarify patients' experiences in waiting for care.

Despite the universal nature of healthcare delivery in Canada, there is a growing concern that patients' experiences in accessing care may vary by non-health-related factors such as socio-economic status (Kelly et al. 2002; Arnesen et al. 2002).

Table 3 represents results for waiting times for specialist visits by income group. Median waiting times for specialist visits remained consistent at approximately 4 weeks across income groups. This finding is consistent with other evidence regarding the association between waiting times and income in Canada (Shortt et al. 2003).

Experiences waiting for care

Waiting for care is not inherently problematic, but may be considered so when patients experience adverse effects, feel they have simply waited too long for care or both (Kelly et al. 2001; Brownlow et al. 2001; Hadjistavropoulos et al. 2001;

TABLE 2. Median waiting times (weeks) for non-emergency surgery by province, Canada, 2003, 2005

	2003		2005	
	ESTIMATE	95% C.I.	ESTIMATE	95% C.I.
Newfoundland and Labrador	4.0 ^E	2.4, 5.6	4.3 ^E	2.8, 5.8
Prince Edward Island	4.3 ^E	2.7, 5.9	4.3	3.3, 5.3
Nova Scotia	4.3 ^E	1.7, 6.9	4.3	3.1, 5.4
New Brunswick	4.3	3.4, 5.2	4.3	3.7, 4.9
Quebec	8.6	6.3, 10.8	4.3 ^{I,E}	2.6, 6.0
Ontario	4.3	3.7, 4.9	4.3	3.3, 5.3
Manitoba	4.3	3.4, 5.2	6.0 ^E	3.2, 8.8
Saskatchewan	6.0 ^E	3.1, 8.9	..	..
Alberta	4.0 ^E	2.5, 5.5	4.3 ^E	2.2, 6.3
British Columbia	4.3 ^E	2.8, 5.7	5.0	3.4, 6.6
CANADA	4.3	3.9, 4.7	4.3	3.9, 4.7

Notes: E - Interpret with caution (high variability)

.. - Data not provided due to extreme sampling variability or small sample size

I - Statistically significant difference between 2003 and 2005

TABLE 3. Median waiting times[†] (weeks) for specialist visits by socio-economic status, Canada, 2005

TOTAL HOUSEHOLD INCOME [±]	MEDIAN	95% C.I.	
Lowest income	4.3	3.6,	5.0
Lower middle income	4.0	1.5,	6.5
Middle income	4.0	3.4,	4.6
Upper middle income	4.0	2.9,	5.1
Highest income	4.0	3.0,	5.0

Notes: † Age/sex adjusted estimates

± Adjusted for household size

Ackerman et al. 2005). While much has been said about patients' experiences in waiting for care in the media and elsewhere, there is in fact very little information at the national level in Canada regarding patients' views and experiences while waiting for

care. The HSAS was designed to gather information in two key areas: acceptability of waiting times and the burden of waiting for care. The information provided reflects the views and experiences of respondents and is by its nature subjective. Responses will be shaped by individuals' own expectations about waiting for care.

Results of the 2005 HSAS indicate that the proportion of patients who felt that their waiting time was unacceptable was highest among those who waited for specialist visits (29%) and diagnostic tests (21%) and lowest among those who waited for non-emergency surgery (16%), even though individuals are more likely to wait longer (i.e., > 3 months) for non-emergency surgical care compared with other specialized services (Table 4). This finding points to potential differences regarding thresholds for unacceptable waits across different specialized services, i.e., Canadians appear to be more willing to wait longer for surgery than for a visit to the specialist.

TABLE 4. Patients'+ experiences waiting for care by type of specialized services, Canada, 2005

	PROPORTION (%)	95% C.I
Those who considered wait time unacceptable		
Specialist visits	28.6	26.1, 31.1
Non-emergency surgery	15.8	13.5, 18.1
Diagnostic tests	20.8	18.2, 23.4
Those affected by waiting for care		
Specialist visits	17.7	15.6, 19.9
Non-emergency surgery	11.0	8.9, 13.1
Diagnostic tests	12.2	9.8, 14.7

Notes: + Based on the population who accessed these services in the past 12 months

Approximately 18% of individuals who visited a specialist indicated that waiting for the visit affected their life, compared with 11% and 12% for non-emergency surgery and diagnostic tests, respectively (Table 4). Between 49% (non-emergency surgery) and 71% (diagnostic tests) of those who were affected reported that they experienced worry, stress and anxiety during the waiting period. Approximately 50% of those who were affected by waiting for non-emergency surgery and 40% of those who were affected by waiting for a specialist visit or diagnostic test indicated that they experienced pain (data not shown).

Limitations

Despite the advantages of the HSAS, there remain several limitations to the data and the analysis presented in this report. The data are based on self-reported information that has not been clinically validated and may be subject to recall bias. To reduce potential error, questions repeatedly referred to services used in the last 12 months.

The results are not generalizable to population groups not represented in the CCHS, including residents of the three territories, those living on Indian reserves or Crown lands, residents in institutions, full-time members of the Canadian Forces and residents of certain remote regions.

Reliable estimates at the national and provincial levels could not be produced for all the variables, given that in some cases, the survey sample was too small to generate reliable estimates.

Conclusions

This report highlights several key advantages of the HSAS, including comparable data across time and space, enhanced patient information and information regarding patients' experiences while waiting for care. The results indicate that median waiting times for all specialized services in 2005 was 3–4 weeks. Results of the 2005 HSAS indicate that there is no relationship between income and waiting times for specialist visits. Further analyses will be conducted to explore this association for other types of waiting times.

While the majority of patients indicated that their waiting time was acceptable, there continues to be a proportion of Canadians who feel they are waiting an unacceptably long time for care and a proportion of those who are adversely affected by waiting for care. Further analysis will be conducted to explore the associations between socio-economic status and patients' views and experiences in waiting for care. While the evidence to date suggests that there is no relationship between income and acceptability of waiting times (Sanmartin et al. in press), socio-economic status may be related to whether or not patients experience adverse events while waiting for care. This is clearly an area for further exploration.

Statistics Canada continues to provide information regarding patients' experiences in accessing care. These data will be further explored to clarify the factors associated with long waits and adverse experiences while waiting for specialized services, including the role of non-health-related factors.

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