

WOMEN and wait times

Why are **wait times** women's issues, and what are the issues for women?

We all want quality health care when and where we need it. Even though wait times for some health care services have been stable in recent years, the 'crisis' of wait times has become a key political issue. Waiting for care is indeed a critical concern for women because they are the majority of care providers (paid and unpaid) and because they are more likely to use the health care system on behalf of others as well as for themselves. So we need to be clear about how waiting—and how we define it—affects women.

- How might differences *between* and *among* women's and men's lives shape their need for and access to certain tests and procedures?
- How might waiting for these tests and procedures affect women and men?
- What are the costs?
- Do official wait times reflect the whole experience of waiting for women and men?

AND:

- What can be done about wait times?
- What is the relationship between wait times and timely access to care?

**We explore these questions through the example
of hip and knee replacement surgery.**

MAKING AN ISSUE OF WAIT TIMES

Newspaper and television reports, news magazines and radio call-in shows are filled with talk about crisis in the Canadian health care system. Sometimes it sounds like our health care system is at the brink of collapse. Many people believe that wait times for care are increasing, and media reinforce this belief by reporting extreme cases of waiting. Women worry about this issue because it represents some of our deepest concerns about the state of our health care system. When we fall ill, when someone we love is sick or injured, will good care be available when and where we need it?

The facts of the matter: beliefs versus evidence

Despite these worries, the majority of Canadians have reported that the time they have waited for care has been acceptable, and while wait times for *some* procedures have increased, Statistics Canada and provincial data suggest that overall, wait times for non-emergency surgery and major diagnostic tests (e.g., MRI scans) have been stable in recent years. Nevertheless, there is growing concern that long waits for health services may have serious costs, may cause harm to patients, raise questions about fairness, and weaken our confidence in the health care system.

But wait times are a normal part of any health care system, and not all waits cause harm. Sometimes a waiting period allows for confirmation of a diagnosis, or time to get a second opinion. Sometimes ‘wait and see’ is the proper medical response because sometimes a problem resolves itself on its own without medical intervention. The important matter is to make sure patients get the care they need at the right time.

Debates and decisions about how to respond to wait times affect women in particular and important ways. Waiting for care is a critical issue for women because they are the majority of care providers—both paid and unpaid, at home and in hospital—and because they are more likely to use the health care system on

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behalf of others as well as for themselves. Yet women and their needs are absent from public and political discussions about wait times. We need to ask some serious questions—of ourselves and our governments—about how waiting for care affects women.

It is not simple to get at these problems:

- Wait times are defined in many different ways.
- The experience of waiting depends on what service you are waiting for.
- There are multiple consequences of waiting.

This document aims to help women understand these issues and raises important questions. We are entering this discussion through the specific example of hip and knee replacements which has been identified by the federal, provincial and territorial governments as one of five areas for action on wait times.



SETTING OUR CLOCKS – MEASURING WAIT TIMES

In the past, researchers and policy makers have not always used the same definition of wait times (when ‘the clock starts and stops’); nor is the way that officials discuss wait times exactly the same as how we use the term in everyday life. Some have said that waiting starts when a patient gets a referral from her family doctor. Some have said it’s when a specialist makes the decision to prescribe a certain treatment. Some have said it’s when a patient gets on a hospital waiting list. Each of these different definitions of wait times refers to different periods of times—some longer than others—and will therefore produce different results when we measure how long a patient waits.

In December 2005, federal, provincial and territorial Ministers agreed that wait time begins when a family doctor or specialist books a service (such as a test or surgical procedure) and ends when the patient begins to receive the service.

The Patient Journey

There is very little information about how women and men are affected differently by waiting, taking into account the kinds of paid and unpaid work they do, the supports they have, or their responsibilities as wage earners and caregivers for family members and others. Standard wait times definitions often don’t capture these differences, leaving out parts of the ‘patient journey’ through the health care system. For example, the Health Council of Canada has described the patient journey as beginning with the patient identifying their first symptoms, and then calling their primary care provider for an appointment. Yet the official wait time for hip and knee replacement surgery has a different start, beginning when a specialist books the procedure.

UNDERSTANDING TERMS

In September 2004, the Prime Minister and provincial and territorial Premiers agreed to make wait times a priority. One part of this agreement was that provinces and territories would come up with “evidence-based benchmarks of medically acceptable wait times” for certain health care services—cancer treatment, heart treatment, diagnostic imaging (e.g., MRIs), joint replacements (hips and knees) and sight restoration (cataract surgery).

A **benchmark** is a recommended maximum wait time for a service—it’s the most time a patient should wait before receiving a diagnostic test or treatment. Benchmarks do not change from region to region, or from hospital to hospital.

There is also talk of targets. These are different from benchmarks. A **target** is the percentage of patients who are expected to receive a certain service within

the benchmark time for that service. Targets are set by provinces, territories, or individual providers. For example, the benchmark for cancer radiation treatment is 4 weeks. A government or health care provider could set a target of serving 90% of patients within that 4-week benchmark. By keeping track of how many cancer patients received radiation treatment within 4 weeks of being referred, that government or provider could assess how well they were meeting this service goal.

Wait times guarantees have also been proposed by various governments. These guarantees are intended to give patients recourse if they do not receive treatment in the benchmark time period. For example, under some proposals, if a patient could not get the service she required within the benchmark time period, her home province would cover the cost of her treatment in another province, territory or country.

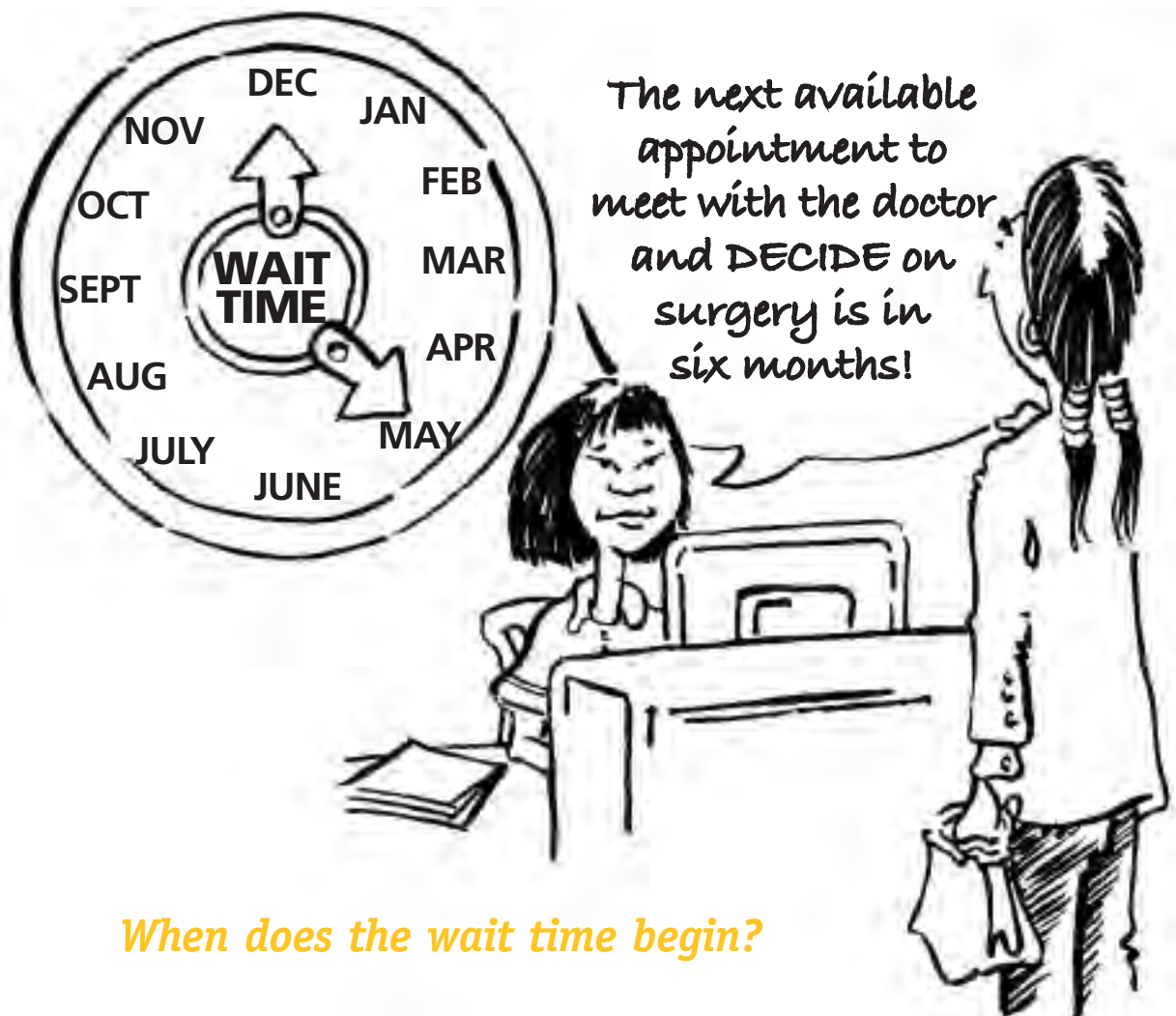
This different definition of when waiting begins excludes an important part of waiting for care. And we know that women and men experience the patient journey through the health care system differently.

In order to understand how waiting for care affects women and men, we must ask:

- What facilitates and obstructs movement through each stage in the patient journey for women and men?
- What do we need to know about underlying health conditions that determine the need for care, patterns of physician referral and treatment, and how women and men experience and report their symptoms?
- Which women and which men? Women and men living in different circumstances are likely to have different experiences of waiting. For example, an elderly woman living alone on a limited pension is likely to have a different experience of waiting than an elderly married man with more financial and social supports (such as a spouse or other family members).

We can apply these questions to the particular example of waiting for hip and knee replacement surgery in Canada.

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LET'S GET PHYSICAL: WOMEN WAITING FOR HIPS AND KNEES

Women's lives are typically different from men's and this affects women's health. In Canada, for example, women tend to live longer than men on average but have more chronic illnesses. Women are also generally less financially secure than men because of different patterns of education, employment, and earnings over their lifetimes. As well, women generally have greater responsibility for caring for others, including children, seniors, and those with chronic illness or disabilities. These patterns of women's lives—in relationships, in work, and in employment— affect women's health and in turn shape both women's health care needs and their use of the health care system including women's experiences of waiting for hip and knee replacements.

Hip and knee replacement surgeries have received a lot of attention in wait times discussions, in part because there is growing demand for these operations in Canada. Between 1995 and 2002 hip replacements increased by nearly 20% and knee replacements increased by over 60%. We know that delaying hip or knee replacement can lead to poorer health and that the costs of hip or knee replacement are lower if done earlier, when there is less disease in the joint. We also know that there are differences between women and men in the level of need for hip and knee replacement, how they are diagnosed and referred for treatment, what supports they have before and after surgery, and what their responsibilities are as wage earners and caregivers for family members—all of which affect their likelihood of being on a wait list and their experiences of waiting. Factors that intersect with gender—like income, education and race— also affect waiting for care.

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Who could benefit from hip or knee replacement surgery?

Arthritis is one of the most common chronic diseases in Canada, and a leading cause of long-term disability, pain and increased use of health care. It is also the primary underlying condition that makes hip and knee replacement necessary—most hip and knee replacements are done to fix the damage done by severe osteoarthritis. Here are some important facts about arthritis:

- Osteoarthritis affects about twice as many women as men.
- Higher rates of arthritis are found among people with lower income and less education.
- Arthritis is the most prevalent chronic condition in the Canadian Aboriginal population and is 10% more prevalent than in non-Aboriginal Canadians. Canadian Aboriginal people have reported that arthritis is one of the five most important health problems in their communities.
- In the U.S., Black women have been found to have higher rates of knee osteoarthritis than white women.
- In general, women with arthritis are likely to be older, have lower incomes, have fewer years of education, and are more likely to be widowed and out of the labour force than women with other chronic conditions. These women are likely to have the fewest resources to deal with their disease and with the impact of both waiting for surgery and recovering from surgery.

Women are more than twice as likely as men to need hip or knee replacement because of higher rates of severe arthritis. In comparison with men, women have more arthritis pain, are more likely to be disabled, and are more likely to need assistance with daily tasks, but are less likely to report getting unpaid help (mostly because they're more likely than men to live alone). Even though women's need for hip/knee replacement is greater than men's, women are three times less likely to have hip/knee replacement when they need it than men.

What are some reasons for this difference between women and men?

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Gender-blind diagnostic tools:

Damage to hip and knee joints is often assessed by radiographic images (such as x-rays). Pictures such as these are generally presumed to measure the severity of damage and disease accurately, regardless of the sex of the person being assessed.

However, these tests may not be able to show how arthritis disease affects women and men differently. For example, one study that examined patients waiting for knee replacement revealed that women had more impairment and disability than men, even though radiographic images showed similar joint damage. In another study, patients' scores on pain and physical function scales one year after surgery did not match what pre-operative radiographic assessments of osteoarthritis predicted. Referrals for hip and knee replacement and management of wait lists guided by the 'objective' tool of radiographic imaging may paradoxically *create* gender inequity, because this tool underestimates the severity of disease and urgency for surgery in women.



Consequently, researchers have recommended that a patient's view of his or her impairment and their ability to tolerate pain should be included in diagnosis and assessment—and patients' symptoms, not radiographic images of joint damage, should drive the decision to refer for surgery.

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Gendered treatment patterns:

In general, women and men communicate with their doctors differently and have different experiences of treatment. That is, women and men may experience their symptoms differently or report those symptoms differently, and doctors may not interpret or act upon women's and men's symptoms in the same way. This seems to be the case with heart disease, for example. A few years ago, health education materials used to tell us that a heart attack felt like a crushing chest pain because that was the way that most men experienced it, but today it is more likely that such material would acknowledge that women may experience the pain as being in the jaw or shoulder as well as in the chest. These differences in the experience of a heart attack have important implications for how both health care providers and lay people identify a heart attack—and whether a person is likely to get the care they need for their problem.

There is much evidence to suggest that doctors make more errors in diagnosis and choose less aggressive treatment options with women than with men. For example, while women report more severe levels of pain, more frequent pain and pain of longer duration than men, women are less likely to receive treatment for it. There are several explanations for this:

- Some doctors may believe that women are better able to handle pain, because women can endure the pain of childbirth.
- Some doctors believe that because women have more and better coping strategies for dealing with pain than men, women need less treatment.
- Some doctors believe women's pain is caused by being overanxious and believe that women are "overly emotional" when they report pain symptoms.
- Moreover, many studies show differences in pain treatment for racial and ethnic minorities—specifically, African-American and Latina/Latino patients are less likely than white people to receive effective pain treatment. So, we are likely to find differences in diagnosis and treatment among, as well as between, women and men.

In the case of arthritis and joint replacement, one study has found that women were more likely than men to seek treatment for arthritis, but women with a potential need for hip or knee replacement were less likely than men to say they'd discussed that surgery with a doctor. So, women are less likely than men to be referred to a specialist, or are referred to a surgeon after a longer period of waiting. This might be so because women are less likely to raise the topic of treatment for their arthritis, or are less likely to demand surgery when it is discussed. On the other hand, doctors may have certain attitudes about the risks of and reasons for hip or knee replacement that lead them to believe men are better candidates for surgery than women.

Gendered decision-making patterns:

Women and men may also have different reasons for and ways of making decisions about whether to seek hip or knee replacement.

Some researchers have found patients' concerns about lack of support after surgery may increase their unwillingness to have hip or knee replacement. Joint replacement is major surgery and recovery is challenging. Often, as people age, they have fewer friends and family to call upon for support, so patients who put off surgery may do so simply because they are unable to get the support they need for their recovery.

Because elderly women are more likely to live alone than elderly men, it is reasonable to assume that women may have more difficulty getting support. In addition, because women provide most unpaid health care within the home, women may be more likely than men to be already *providing* support than receiving it. We need to consider how hip and knee replacement referral rates for women and men are affected by levels of social support, which may in turn be influenced by a combination of gender, age, income and other factors.

Who's going to do all this
if I go for surgery?
...and who will look after me?



WOMEN WAITING TO WAIT FOR HIP OR KNEE REPLACEMENT

Women with hip or knee osteoarthritis spend a lot of time “waiting to wait.” Even though women report greater pain and disability than men, women more often wait to be referred to orthopaedic surgeons and to be referred for surgery. But this stage of waiting is not reflected in official wait times data. Because wait time is defined as the time between booking and receiving a procedure, the extra time that women wait is effectively made invisible and thus is not part of official wait times discussions. Presently, the definitions of wait times and the wait lists for hip and knee replacement obscure the differences in women’s and men’s patient journeys through the health care system.

The goals of reducing wait times include: reducing suffering, improving quality of life, reducing further costs to the health care system by treating people earlier in the course of illness, and ensuring the system operates fairly. But these goals can’t be met if the people with the greatest need are not recognized and do not make it to the list in the first place.

It’s also important to acknowledge that the patient journey does not always end with recovery from surgery. There may be complications, surgery may be required on the hip or knee of the other limb, or recovery may be partial. Hip or knee replacement surgery illustrates a particular kind of health intervention, one that follows a largely straightforward path. We need to recognize that many women live with chronic conditions or have health problems that are not resolved by a single, major intervention.

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WHAT CAN BE DONE ABOUT WAIT TIMES?

In the case of hip or knee replacement, and in other clinical areas, the measurement of wait times—when the clock starts and stops—must take into account women’s and men’s different journeys through the health care system.

Data in wait time reports should be reported for women and men across a range of social locations—race and ethnicity, age, income, disability, geographic location, etc.

Clinicians who have the power to “start the clock” must better understand the contexts of women’s and men’s lives so they can better assess women’s and men’s symptoms and needs, both before and after treatment.

Gender-sensitive diagnostic and referral tools should be developed and implemented.

Construction and management of wait lists should take into account supports that both men and women need post-intervention.

CRITICAL QUESTIONS: HOW TO ASSESS TALK ABOUT WAIT TIMES

As debates about wait times continue and new policies to address wait times are developed, we must insist that these debates and policies take into account the contexts that shape women’s and men’s lives. We must ask critical questions to ensure that the issues for women are fully understood and addressed, such as:

- How are wait times defined? When does the ‘clock’ start? Does the definition include all the parts of waiting?
- Who is waiting?
- What service is she waiting for?
- Is there any discussion about the supports women need while they wait?
- Does lack of support before, during, and after reduce someone’s willingness to undergo a procedure?
- Does the discussion address why some people don’t make it to the waiting list in the first place?

FOCUSING ON TIMELY ACCESS

While wait times for a handful of highlighted services have received most of the press coverage in recent months, we want to expand the debate on wait times to include *timely access* to care.

We must begin by asking what services are needed, where they are needed, and for which women. Are the women who most need the services able to get them in a timely way? Women's care responsibilities may mean they cannot leave home to get care when they need it and women in rural communities face particular problems of transport, distance and support. Once women are in the health care system, are their symptoms understood and treated appropriately? How do they experience their treatment? Are the women who provide care (at least 80% of paid and unpaid care providers are women) adequately supported in their work? We must think beyond discharge to follow patients home, where women are more likely to live alone and be responsible for the care of others. How do circumstances at home affect treatment decisions and access to care?

Talking about timely access focuses attention on the entire patient journey rather than only one segment. And it broadens the scope of the debate to include the causes of illness, the conditions that affect getting to care, the approaches to diagnosis and treatment, the experiences of waiting, and the outcomes of care. A focus on timely access to care also considers women's unique roles as providers, patients and decision-makers in health care. By taking all these elements into account we can better understand the concerns of women waiting—and 'waiting to wait'—for quality health care.



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who we are and what we do

Women and Health Care Reform consists of Pat Armstrong (Chair), Madeline Boscoe, Barbara Clow, Karen Grant, Margaret Haworth-Brockman, Beth Jackson, Ann Pederson and Morgan Seeley. We are a collaboration of the Centres of Excellence for Women's Health, the Canadian Women's Health Network and Health Canada's Bureau of Women's Health and Gender Analysis, funded through the Women's Health Contribution Program. Our mandate is to coordinate research on health care reform and to translate this research into policies and practices. For more information on our work, visit our website at www.womenandhealthcarereform.ca. Contact us at whcr@yorku.ca

For more information about the Women's Health Contribution Program visit: www.cewh-cesf.ca

ordering information

Copies of this booklet can be downloaded from www.womenandhealthcarereform.ca or ordered free from:

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*“Improving access to care
is more than just speeding
access to elective surgery.
It's also about appropriate,
timely interventions along
the full spectrum of care.”*

**Charles E. Pascal, 2006. “Romanow, Romanow,
where art thou?” *The Globe and Mail*, March 7, A15.**



Thinking Women:

A Series on Health Care Reform and Women