Wait Times FAQ

Q: Canada, the UK, and other countries are often held up as model single-payer health care systems, yet we persistently hear of long wait times for appointments and services. Is this what we can expect from a single-payer system?

A: Numerous careful studies have found that the insurance and financing system is not responsible for long wait times. Excessive wait times can be found in all systems, single-payer or multi-payer, public, mixed, or private, and can occur within systems by region, state, province, county, municipality, or even individual medical facility or practice. The most important factors affecting wait times include physician shortages, limited hospital facilities, funding constraints, and poor patient flow management.

The "wait time issue" is important. No one should have to suffer pain and anxiety while waiting for diagnosis or treatment, or be forced to remain away from work or school for unnecessarily long periods. Nor should they be placed at increased risk of death or disability.

The Organization for Economic Cooperation and Development (OECD), a grouping of the major industrial countries, has undertaken extensive studies of their health care systems, including variations in wait times. All of these system but that of the US provide universal coverage with comprehensive financing and rich data sources. In all of them, government has a major role in the health system, so waiting times for elective procedures have often become a contentious political issue. In 2001-04, many of them were concerned about waiting times, and OECD began reviewing policies for reducing waiting times.

A major study completed in 2013, Waiting Time Politics in the Health Sector: What Works?, evaluated what progress had been made in that period. Not surprisingly, they found that countries that spend more on health care, had increased their supply of physicians, and had greater hospital capacity experienced shorter waiting times. In some cases, they had adopted waiting time guarantees or targets to place pressure on those working in these systems, and these incentives were effective when they were enforced.

Most important, these studies found that it was these capacity and budget factors, not the nature of a country's health care financing system, that determined the existence and length of any delay for receiving care.

There has recently been great concern about excessive wait times in Veterans Administration facilities. An independent assessment conducted for the American Legion found that "wait times at the VA for new patient primary and specialty care are shorter than wait times reported in focused studies of the private sector." Overall, the report concluded, "VA wait times do not seem to be substantially worse than non-VA waits."

Emergency services

With respect to potentially life-threatening emergencies, all advanced countries use specially designed and tested triage systems to ensure that high priority emergency room (ER) admissions are treated immediately upon patient arrival in cases needing resuscitation, and in less than an hour in cases considered of "emergent" or "urgent" acuity. Under most conditions, high priority wait time targets are met in the vast majority of cases in all advanced countries.

If target times are not met, there are usually external reasons. In rural hospitals it might be due to travel time for surgical specialists. In heavily-used urban hospitals, delays are often a function of temporary or, in extreme cases, chronic ER crowding. Recent cutbacks in National Health Service funding in England, as another example, have affected ER wait times.

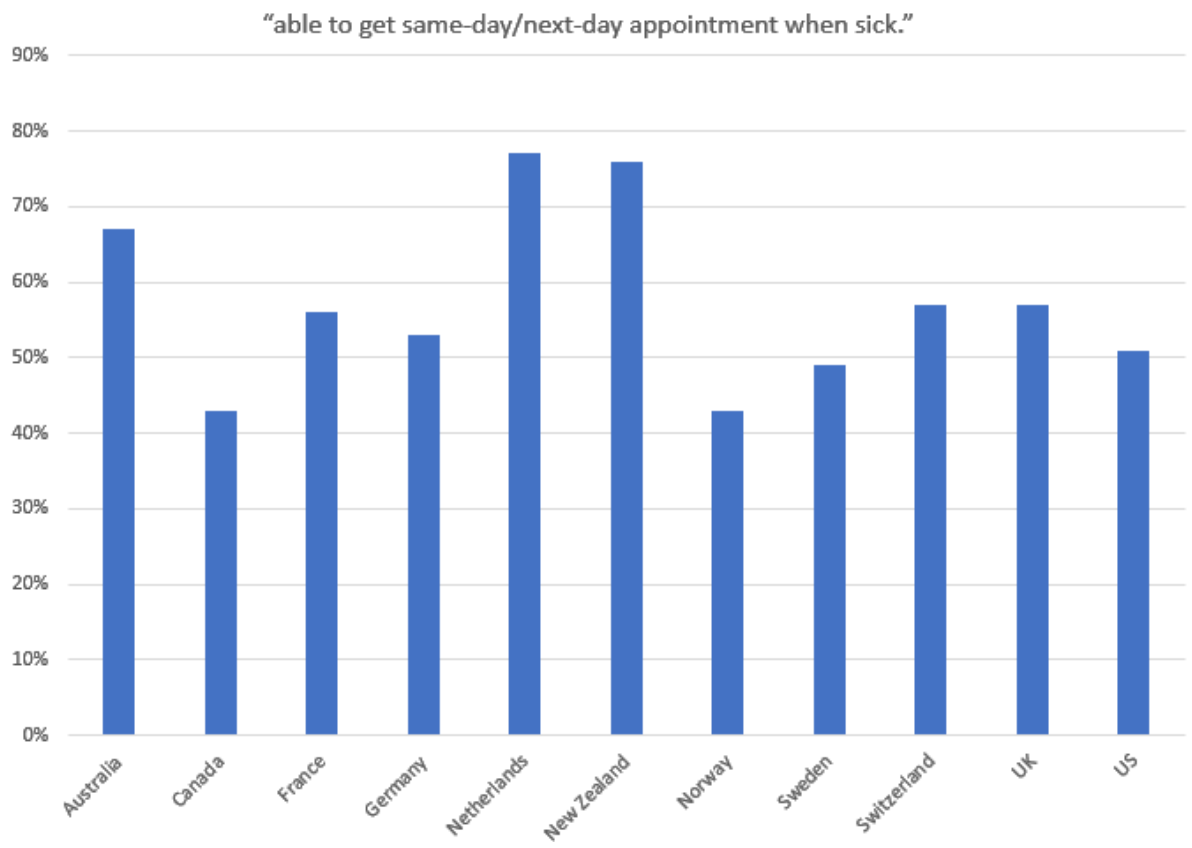
Crowding is especially prevalent in ERs that serve large numbers of patients who do not have true emergency problems. In a 2013 Commonwealth Fund study involving 11 advanced nations, the US had the largest percentage of such patients, due primarily to inadequate or no insurance.

The same study showed that the US and Canada had among the largest percentage of non-urgent ER admissions due to difficulties getting appointments with primary care physicians. Yet France, Australia, and the UK, all with universal health care systems, single-payer and multi-payer, had 40-60% fewer such admissions. Germany and The Netherlands, also with government-regulated universal systems, reported the overall percentage of ER use at only 25-35% of that of ERs in Canada and the US

Wait times for emergency services can vary widely among countries, and among regions and hospitals within countries. There is no correlation based on national financing system. Single-payer countries are among the best and the worst with respect to ER wait time. After years of improvement, the National Health Service in England, for example, has experienced a recent worsening of ER wait times, while the nearly identical program in Northern Ireland recently reported that 95% of ER patients get a triage assessment within 8 minutes and are seen by a medical professional within 29 minutes, both excellent results.

Wait times to see a primary care physician when sick

As noted above, a major reason for crowded ERs is a person's inability to get an appointment with a primary care physician to treat an acute condition which is not a true emergency. A 2016, 11-nation Commonwealth Fund survey found the following results for adults "able to get same-day/next-day appointment when sick."



Same-day or next-day access to primary care in Canada and the US is below the 11-nation average, yet one has a public single-payer health insurance system and the other a private market-based system. The fully nationalized UK system does better than both. In any case, there is little difference among these countries having very different financing systems.

Managing patient flow is of critical importance in meeting wait time goals and there are many aspects to this management. Limited physician networks in the private US system are a typical source of long wait times. Physicians refusing Medicaid patients create long delays in the US public system as well, affecting wait times for the poor and driving them into emergency rooms. The single-payer Medicare system in the US, on the other hand, has fewer network restrictions and better primary care wait time results, on average, than both private and Medicaid patients.

The availability of evening and weekend hours can mitigate wait time problems as can the availability of urgent care walk-in clinics. Increased use of nurse practitioners and physician assistants can address wait time problems in areas with physician shortages or long travel times.

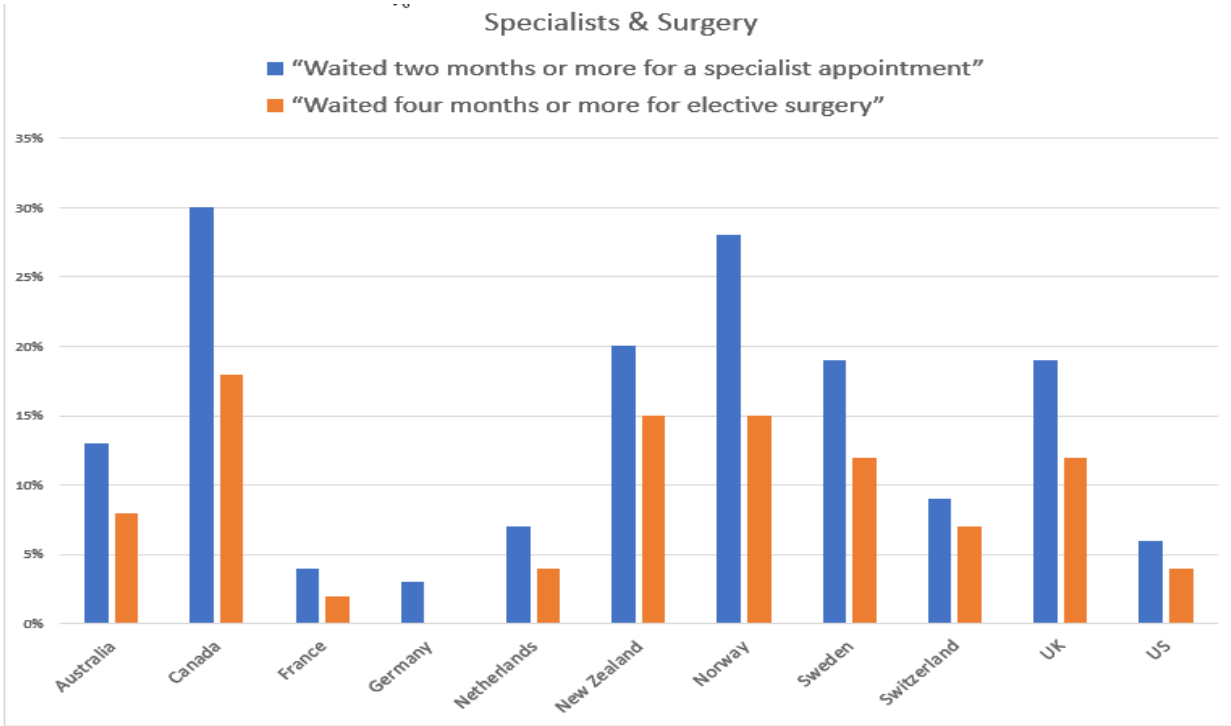
Countries, regions within countries, and individual facilities and practices vary widely in their ability to manage patient flow. The variation cuts across all modes of health insurance financing.

Wait times for non-urgent care and elective procedures

Many of the complaints involving Canadian, British, and other single-payer or multi-payer universal systems relate to care that is not urgent or involves elective procedures. This could be first-time visits with a new provider, annual check-ups and screenings, visits to specialists, or non-urgent or elective surgery such as hip and knee replacement or cataract surgery. Long wait times in these situations can be a direct product of patient flow management as providers prioritize care for those with more immediate needs, or can result from physician supply constraints due to many of the same factors as described above.

Following years of steadily improving service including reduced wait times, the Canadian Medicare and English National Health Service systems have experienced substantial increases in wait times for non-urgent services since the recent recession. This has generated public discontent and a barrage of press stories describing some of the worst cases. As a result, public officials have prioritized the issue, and both systems have begun using improved patient flow management systems coupled with penalties or rewards for meeting, or failing to meet, the targets. More importantly, targeted spending has increased in response to public concern about the problem.

Here are the data from the 2016 Commonwealth Fund study relating to non-urgent wait times:



The US fares better in this category than Canada and England and even Norway and Sweden, and much has been made of this fact. However, the universal social insurance systems of France, Germany, and the Netherlands fare just as well as the US

The New York Health Act and wait times

The New York Health Act will remove many of the sources of long wait times in the US. There will be no limited provider networks, and providers will no longer discriminate against Medicaid and Medicare patients, since reimbursement rates will be standardized. There will be no barriers to provider choice, creating a greater range of options, especially in urban areas with greater concentrations of providers.

With reduced paperwork and administrative burden, providers will have more time to devote to patient care and the management of patient flow. This will be especially important in the face of the expected increase in utilization of health care services. Hospitals, too, will be relieved of an administrative burden and be able to devote more resources to patient services.

In the longer run, NY Health planners will be able to work with the Governor and the Commissioner of Health to increase the supply of providers in rural areas and to provide the necessary capital for expanding patient care facilities and diagnostic technology where it is needed.

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