The paper studies the effects that supply and demand factors have on waiting lists (WL). The first part of the model defines a theoretical approach to waiting list, defined as the excess of demand in an equilibrium function between supply and demand of healthcare. In the second part of the paper the authors apply their theoretical model in an empirical analysis of Spanish data.

In general, the authors should extend the description of Spanish Healthcare System, in order to allow the reader in understanding the implication of the theoretical part to the applied part of the paper.

In particular, the role of the private hospitals in the healthcare system has to be more explained. The difference in terms of penetration of the private hospitals in the market areas, it implies an impact of the WL for public hospitals. But in order to understand this impact in Spanish healthcare System the reader needs more details to understand how do the private providers act in the hospital market.

Page 10: what do the authors mean exactly with "protected population"? It seems that there is no way for patient to choose an hospital regardless his clinical condition. It seems also that hospitals or the GPs can not move patients to another hospital in case when they consider this hospital as a better solution for the patient's health status.

Page 10/11 in case of budget constrain, like the authors describe in the paper, it could be accept to exclude the objective of profit maximisation, but the authors should more discuss this budget constraint in particular with the aim to study WL. In fact, in a context of cost containment and budget reduction, as in all the western countries, it could happen that for some hospitals the budget is not enough to provide the same services' supply and this has a direct impact on WL. The authors say something about this in the comment of figures but this point need to be extended in the firs part of the paper.

I do not understand whether the authors refer their model only to the inpatients services or this can be applied for both outpatient and inpatient services. Maybe in the case of inclusion of outpatients the theoretical model should be extended?

Fig 1: I think that "O" should be substituted with "S"

Most in general some of the points shortly discussed in the comment at figure 1 and figure 2, should be more detailed in the first part of the paper where the authors present their theoretical approach to WL.

The application does not help to support the theoretical part of the paper. First of all, the data collected by this survey can be limited in terms of quality. For example, the respondents can reduce the real value of their WL. Secondly, I have some concern in considering medical and surgical WL together as well as I think that an application about WL should be detailed in single procedures. For example, in some healthcare systems there are procedures that must be delivered within a time fixed by law.
Furthermore, the model considers the WL of a region. I think that hospital data can help to improve the quality of the applied part of the paper. A regional WL is a weak measure of quality, is a kind of regional average of all the WL related to all the procedures delivered in a hospital.

The results of the applications as well, are not convincing me. It seems that there is only two regions different form the others and there are significant effects only at 10% after 2005. Maybe in 2005 there have been some exogenous shock that decrease the WL? The result about limited regional differences over time maybe can be a direct consequence of the analysis at regional level, as explained in my previous comment.

In conclusion, I would like to encourage the authors to deeply revise the paper including more detailed explanation of all the elements that contribute to WL, and moreover to find more interesting data in order to support the theory with a strong application. For all these considerations, I do not consider this version of the paper suitable for publication in this journal.