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Comité Permanent des Hôpitaux de l'Union Européenne
Ständiger Ausschuss der Krankenhäuser der Europäischen Union

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Measuring and comparing

WAITING LISTS

A study in four European countries

Third report of
HOPE's Working Party on Management of Waiting Lists
Brussels, April 18, 2004

1. Introduction

Timely access to health care services is a primary concern in the health care debate in many countries. Different policies to address long waiting lists have been tried - some of them being more efficient than others. However, of great importance to the management of waiting lists and actions against long waiting times is to have reliable and valid information on waiting times. Measurement is crucial to understanding how any system works; where a system contains problems, it is the key to finding solutions.

Comparisons between different health care systems are always interesting since learning about others can be a way to greater understanding of one's own system. The aim of this report is therefore to describe and compare how waiting lists are reported and monitored in four European countries. A summary of difficulties and pitfalls in connection to waiting list measurement and statistics are also presented in the report.

This is the third report from Hope's Working Party on Management of Waiting Lists.

The first report 'Measures to reduce surgical waiting lists' was published in 1998. The purpose of this project, involving Finland, Spain and Ireland, was to examine measures taken in recent years to reduce hospital surgical waiting lists in each of the participating countries. Measures taken to manage waiting lists were also to be addressed.

The results of this project led HOPE to the decision to start a new project in 1999, again involving Finland, Spain and Ireland and also Sweden and the Netherlands. The participating countries each nominated persons within their country to the project to form a working group.

Waiting Lists and Waiting Times in Health Care – Managing Demand and Supply was the title of the second report published in 2001. In this report the working group investigated explanations for the existence of waiting lists.

In the summary of the report the group states: "In general, an excess of demand over supply causes waiting times and waiting lists. Elimination of waiting lists and waiting times in the public medicine system is impossible. As long as the use of health care services in principle is free, waiting lists will be a part of the health care system. Waiting lists becomes an instrument for rationing demand and prioritising supply. Since we see that countries with more or less similar funding systems still have different problems, there must be reasons explaining the length of waiting lists and waiting times.

These reasons could be:

- A lack of resources or / and capital;
- A lack of personnel;
- Bad management of waiting lists or / and inefficiency.

At last, but not at least, a reason for differences, both in and between countries, is a different way of registration of waiting lists."

The work presented in this report is a follow up of the last reason for differences in waiting times between countries. The method used is a questionnaire covering the following issues:

1. **Waiting times and process: three examples (coronary by-pass operation, cataract removal and hip replacement)**
2. **The system for referral and decision to treat and reporting and monitoring of waiting times for elective surgery**

The importance of having good information of waiting times, and the difficulties there are today in getting reliable and comparable statistics, were also addressed by the OECD expert group on waiting times (1). In their report the following recommendations are made concerning further research and data collection[1]:

"One of the main obstacles in improving the efficiency of the public provision of surgery, and to achieving optimal waiting times, is the fog of uncertainty which surrounds the phenomenon. There is both 'clinical uncertainty' and 'policy uncertainty'"
"Similarly better information is needed for benchmarking levels of elective surgery both within and between countries. The data available at international level on surgery (particularly day-surgery) rates are full of gaps……."

The members of the HOPE Working Group on Management of Waiting list in elective surgery have been:

Marianne Hanning, Sweden (chair)
Carmen Martinez de Pancorbo, Spain
Juha Metso, Finland
Mary O'Connell, Ireland

The report is written by Marianne Hanning, Federation of County Councils, Sweden.

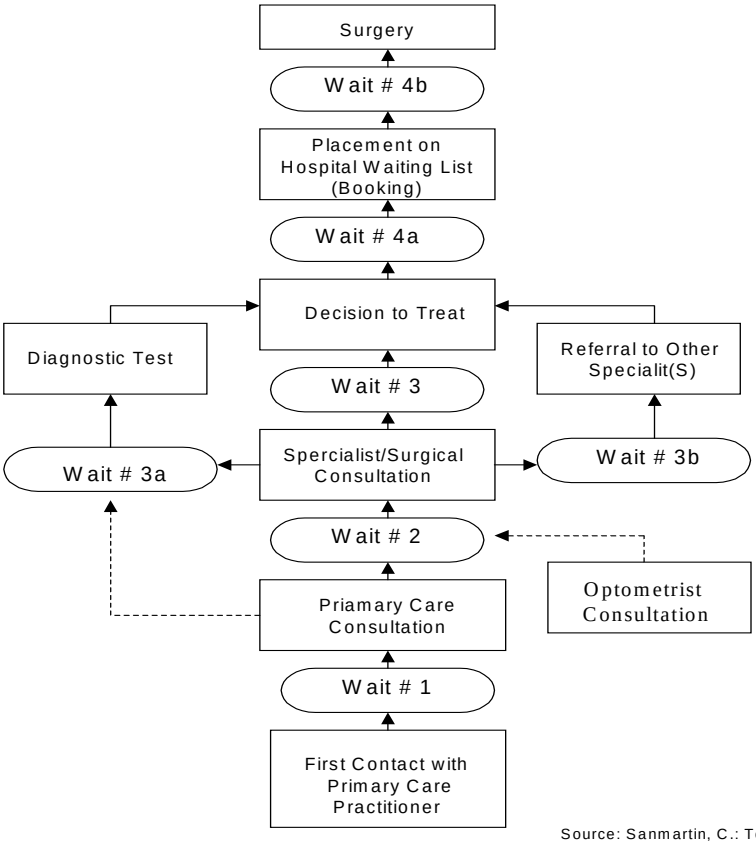
[1] Annex 1 reviews all the OECD recommendations for research and data collection as well as recommendations for policies on waiting times.

2. Measuring Waiting Lists and Waiting Times – important questions to be asked

2.1 When does waiting start and when does it end?

Medical care is a process, i.e. a chain of decisions and actions taken over a period of time. The different steps and waiting times in the surgical process are described in Figure1 (2).

Clarity on when the measuring of waiting time shall start and stop, or what parts of the chain that shall be included is of course crucial in the interpretation of waiting time statistics.



Source: Sanmartin, C.: Toward Standard Definitions for Waiting Times. Healthcare Managment Forum

Figure 1: Waiting Times for Surgery

According to Figure 1 there are at least four possible waiting periods before the elective patient reaches the date for surgery. It is:

1) Wait for primary care
2) Wait for specialist/first visit
3) Wait for decision to treat
4) Wait for surgery

The process can also include waits for diagnostic tests or referrals to other specialists. There can also be waiting for administrative reasons, like waiting to be booked on to a waiting list.

Statistics on waiting times can cover all of those waiting periods or just one or a few of them.
Usually waiting time statistics refer to wait # 2, i.e. out patient waiting time and wait #4, i.e. in-patient waiting time. However as can be seen from Figure 1, in-patient can refer to either time between decision to treat or from the time the patient is actually put on a waiting list. In some countries waiting for surgery is recorded as the time from referral from the GP to surgery, i.e. the wait #2, #3 and # 4 all together.

2.2 Retrospective waiting time, or waiting time for patients on the list?

This is probably the most crucial question in relation to measuring waiting lists, and where there are dividing policies in different countries. Waiting times for those on the list also include patients that will not be treated in the future. Furthermore, measuring waiting times for patients on the list will give low priority patients an overrepresentation since higher priority patients will be treated faster and will constitute a greater part of the output than on the waiting list. Therefore, measures of waiting times for patients on the list will probably be longer than for measures related to retrospective waiting times.

2.3 Waiting times for patients leaving the list?

An alternative to measure waiting time for patients on the list is to measure time for those who are leaving the list. On one hand this is a measure of the real waiting time, but the measure will still include patients who will not be treated.

The information on the reasons for patients leaving the waiting list -, e.g. the patient is going to get surgery, o the patient is not suitable for surgery any longer, or the patient is dead - is of course valuable. However, the waiting time for those patients as a group seems to be less important.

2.4 How is priority treated in the measuring?

Waiting-time to health care is strongly related to clinical urgency and priority setting among different needs. Therefore most health care providers triage patients into different urgency groups. The first level of triage is to separate emergency or acute care from electives. Even if the discrepancies between the clinical judgement of emergencies is small, differences between the organisation and management of patients in different countries can lead to different patient "pathways" which can cause problems in comparing waiting times.

The next level of triage is to separate the electives into different groups. How this is done is sometimes regulated, but in many countries this is a question of local clinical praxis. Figure 2 shows an example from a Swedish study on 15 different standard referrals to orthopaedic care (3).

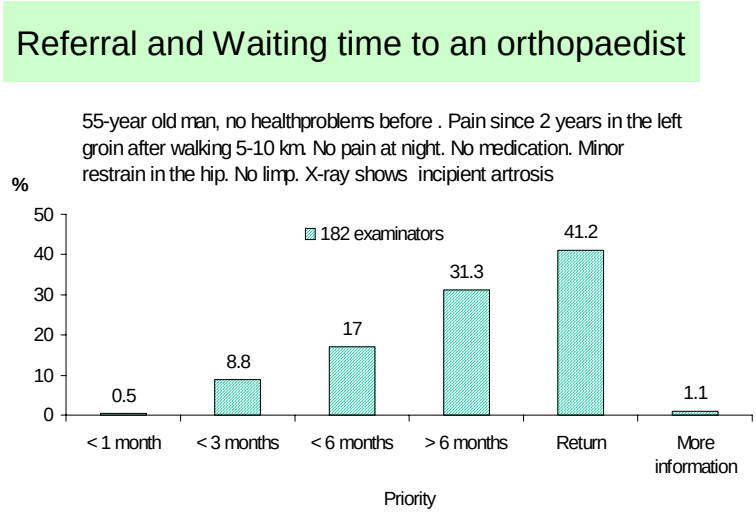
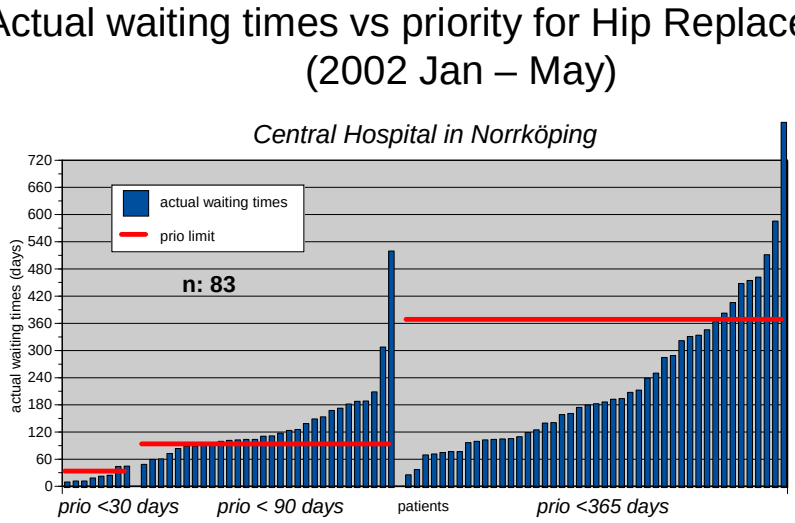


Figure 2: Example of prioritisation of a referral to elective care. Source (3)

Important to notice is that, because waiting time is related to clinical urgency, a good quality measure of the waiting list management in a system is to what degree the patients are treated in time of their individual clinical urgency (se example in Figure 3).

Figure 3: Clinical priority vs. actual waiting time



Prio group	treatment on time	Prio group	treatment on time
Prio <30 days	**75 %**	**Prio <365 days**	**82 %**
Prio <90 days	**23 %**	**Overall**	**60 %**

2.5 In-patient vs. day-surgery - single measure or separated?

The development of day-surgery has been rapid and for many procedures it is the dominant form of care in surgery. In many countries the health care statistics separates between the two forms of care, whereas others report them together or only the inpatient surgeries. Since there is a tendency for the waiting-times to be shorter to day-surgery it is important to know for e.g. benchmarking and comparison if the waiting time measure includes day-surgery or not.

2.6 Mean waiting time or median waiting time?

If the distribution of waiting times is normal then the mean could be used as a reliable measure. However, if there is an imbalance in the distribution using a mean could give a false picture. In those cases the median is a better measure.

For most waiting lists the distribution of *retrospective waiting times* is not normal, since there is a "tail" of a relatively few long waiting times, while most patients have a quite short waiting time. Using the mean as a measure in those cases would give the few long waiting times an un-proportional influence of the measure. On the other hand, if the waiting times for patients on the list are used as a base, there is a probability of the distribution to be more normal and the mean can be as good a measure as the median.

2.7 Seasonal variations?

At least in some countries there are differences in the activity over the year. In the summer season when most of the employers have vacation the activity in electives is lower than over the rest of the year. In such circumstances it is important to compare measures from the same periods or dates.

2.8 Who shall use the data?

There are many circumstances that must be considered when waiting times are going to be measured and monitored – especially if they are going to be compared over time, between units, and not least between different health systems and countries.

Important for the design of the measures is the aim of the measuring and who will be the presumptive user of the statistics.

At least four different subjects with different demands can be identified as stakeholders to data on waiting times:

- Patients
- Physicians
- Managers
- Politicians

The patients as consumers want to know how long they have to wait at different units and that the waiting time is proper, i.e. that there are no medical risks connected to the waiting. Also, patients have an interest in that the treatment process is efficient, of good quality and rapid. The waiting time that is most interesting for the patients is the prospective one, i.e. how long time a new patient has to wait.

The prospective waiting time is also of interest to the GPs that are referring patients to specialist care. Specialist doctors on the other hand are probably more interested in knowing the number on the waiting list and how long they have been waiting. As a doctor responsible for some kind of elective surgery it is also valuable to have the retrospective waiting times as a follow-up of the indications used and the priority setting.

Reliable and valid waiting time date is, like other performance indicators, of great significance to the managers of health care organisations. Waiting time is a quality indicator and it can be used for planning and follow up of the organisation. Bad management and long waiting lists is also expensive to the organisation. Thus, from a managerial point of view it probably is more interesting to be able to compare different units over time by using retrospective data on waiting times.

Politicians and policymakers have an interest in getting knowledge about how the health system performs. In many surveys to patients and citizens problems with access and long waiting times is the prime reason for critique of the system. Therefore, monitoring of waiting lists and waiting times is a question of legitimacy for those in charge of the health care system.

3. Comparing waiting lists and waiting times – surgical rates and indications.

The significance of waiting lists and waiting times in elective surgery can't be understood without knowledge of surgery rates and clinical praxis of indications and priority setting.

If a unit (or a county) have longer waiting times than another the waiting as a problem is quite different if the unit has a surgery rate far over the other unit. Therefore comparisons of waiting time must be done in connection to surgery rates.

One experience of policies to take care of long waiting lists to electives is that more resources seldom are the single solution. After an initial drop in waiting times they start to grow again in spite of a higher surgery rate. What happens in many cases is that there is a change in the indication level for treatment. Patients that before would never have been considered for a surgery can, due to new and more effective methods, be operated on. The development in cataract surgery can serve as an example of this phenomenon.

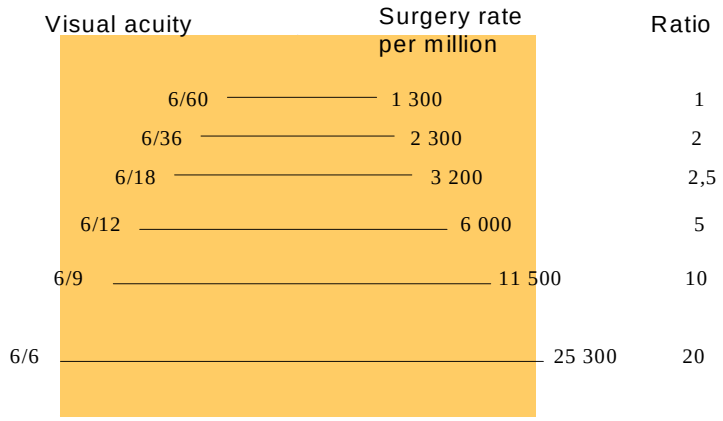


Figure 4: The golden triangle of ophthalmology: the relation between different thresholds of visual acuity and the cataract surgery rate. Data recorded from the Visual Impairment Project in Australia (4).

In a recent report from the Swedish Federation of County Councils (5) operation rates in different European countries and for the three types of surgery that is covered by the Hope-survey in this report, are compared (Figure 5-7).

Also, in the report from the OECD on waiting times (1) there are comparisons of waiting times and surgery rates for a sample of procedures (see Annex 2).

(Figure 5-7, see separate attachment)

4. Gaining Access to Surgery

In order to understand the process of gaining access to surgery for the majority of patients in the four countries the following questions have been asked. The questions are divided into different processes of becoming an elective surgery patient.

1. Referral for elective surgery (outpatient appointment)

2. Setting a date for an outpatient appointment

3. Decision to treat

4.1 Referral for elective surgery (outpatient appointment)

Question 1: Are there any guidelines to inform referrals about EBM or agreed recommendations on indications for treatment for the more common *conditions?*

In Ireland, Spain and Sweden there are no guidelines for indications etc. The Finnish Medical Association and STAKES (the national R&D organisation for health care) has developed a comprehensive EBM-programme for GPs that can be used as a source for information for the decision to refer a patient.

Question 2: How does the General Practitioner/specialist refer a patient to a hospital?

- **Using a Proforma (Please include an example, where possible)**
- **By letter**
- **By computerised booked admission**
- **By telephone**
- **Other, please specify:**

In Finland and in Ireland the doctors write referral letters – in Ireland the letter is handwritten.
Both Spain and Sweden has hospital or health authority developed Pro-forma for referrals.

None of the countries has up to now in a broader sense, developed e-referrals or computerised booked admission. Neither have any of them any bookings made by telephone.

Question 3: To whom does the specialist/primary care practitioner refer?

- **Specific Consultant**
- **Hospital**
- **Other, please specify**

In all four countries referrals are addressed to a specific consultant. In Ireland, Spain and Sweden a referral could also be sent to a hospital department without specification of a receiving doctor.

Question 4: Is there any Patients Rights about the choice of hospital and/or doctor that will receive the referral?

Yes No

If yes, please give a short description

Patients in Finland are not entitled to choose hospital or doctor when they are referred. Slightly different information is given in the county report to the OECD project on waiting lists. There it is said that patients in the Helsinki-area are entitled to chose hospital with shorter waiting times within the area, and that this possibility is spreading to other areas in the country.
In Ireland patients can ask to be referred to a specific consultant but there is no entitlement or right to choose a hospital or consultant. If patient want a specific consultant, they may have to wait longer.

In Spain patients can chose doctor in 13 specialities within their reference area or hospital.

In Sweden the majority of county councils have no formal referral claim for patients to go to a hospital specialist. However, most hospital departments prefer to get a formal referral and patients without a referral in most cases are judged to be non urgent and therefore have to wait longer. For childcare, gynaecology and psychiatry there are free access to specialists all over the country.

Since 2002 all country councils in Sweden have agreed to follow a recommendation from the Federation of country councils stating that patients can seek specialist care all over the country, given they have a referral from a specialist. There are limitations for highly specialised regional care. For more costly treatments there must be an agreement from the home county for the payment. Patients always have to pay themselves for transport costs in those cases.

Question 5: Who determines the unit or doctor to whom the referral is made?

- **The GP**
- **The patient**
- **The purchaser**
- **Other, please specify**

In Finland the GP makes all decisions about the direction of the referral. In Ireland the answer is also the GP/Specialist, with a comment saying that: “they build up a pattern of referrals with consultants, which probably is the case in all of the four countries.

Spain has made a specification saying that the referrals are made: 1) According to residence area and 2) According to agreements between regional health services.

In Sweden the most common case is that it is the GP/specialist who determines where to send the referral. However, since Swedish patients have the possibility of seeking a specialist practically all over the country it is also possible for the patient to make this decision. Also in Sweden, some county councils have a provider/purchaser split which has an influence on the referral pattern. This is probably comparable with the second paragraph in the answer from Spain.

Question 6: Is there any wait for the patient associated with obtaining funding for elective surgery?

Yes No

If YES how long might that wait be? When might it occur?

None of the four countries has a system where this situation is relevant.

4.2. Setting a date for an outpatient appointment

Question 1: At what stage is the patient given an appointment date at the receiving unit?

- **At the time of referral**
- **At a specified time before the appointment**
- **Other, please specify**

In Finland and in Spain the patient is given a date for the appointment at the time of referral.
For the patients in Ireland and Sweden the date can be set at this point, but it is also common that the patient is contacted later at a specified time before the appointment is going to take place.

In Sweden the patients often do not get a specified time for the appointment at the referral when the waiting lists are longer than three months. This is because the doctors´ working schedules only covers three months periods. In those cases the patient only gets a proximal waiting time period.

Question 2: At what point does the doctor, to whom the patient has been referred, generally see the details of the referral?

- **Immediately when the referral is made**
- **When an outpatient appointment date is given**
- **At the outpatient consultation**
- **Other, please specify**

In Finland, Spain and Sweden, the specialist usually sees the details of the referral for the first time at the outpatient consultation. In Ireland it is common that the doctor gets the information about1-2 weeks after the referral is made.

Question 3: How is the date for an outpatient appointment decided?

- **The receiving doctor assigns a date**
- **An administrator at the receiving unit assigns a date**
- **The GP books a date in consultation with the patient**
- **Other, please specify**

In Finland the GP suggests a date and the consultant confirms the urgency. In Ireland and in Spain this is a task for an administrator at the receiving unit. In Sweden it is also the

administrator that assigns the date. However, at least for Sweden, the administrator is guided by an indication of urgency or priority set by the physician.

Question 4: How are patients prioritised for an outpatient appointment?

- **According to when referral received**
- **Consultant decision**
- **Priority criteria**
- **Other**

In Finland and in Ireland the prioritisation is entirely a consultant decision. In Spain patients are prioritised according to when the referral is received and two priority criteria (preferent/normal). For Sweden the priority is also a consultant decision but usually the units use some kind of priority grouping like; very urgent, urgent and no priority.

4.3 Decision to treat

Question 1: How is priority for treatment usually decided?

- **According to established priority criteria**
- **According to clinical criteria determined by the particular surgeon**
- **By the length of time on the list**
- **Other, please specify.**

In Finland, Ireland and Sweden, it is the particular surgeon that sets the priority in accordance with the clinical criteria for the individual patient. In Spain the time the patient has spent waiting is also considered when the consultant decides about the priority.

Question 2 How is a date for the procedure decided?

- **The surgeon assigns a date**
- **An administrator at the receiving unit assigns a date**
- **The surgeon books a date in consultation with the patient**
- **Other, please specify**

In Finland and in Ireland this is a managerial matter and it is an administrative task. In Spain all three alternatives are valid. In Sweden this is also an administrative matter but often the date is set in consultation with both the consultant and the patient.

Question 3: When is the patient notified of a date for the procedure?

- **Immediately, at the time that the decision to treat is made**
- **At a specified time before the procedure is to take place**
- **Other, please specify**

In all four countries the most common situation is that the patient gets the information at a specified time before the date for surgery.

4.4. Summary

The procedure of becoming a patient ready for elective surgery, i.e. the referral-process, getting a time for appointment and the scheduling an prioritising of patients for surgery, is very much the same in all four countries. However there are some differences to be noted.

In Sweden the patient is freer in seeking specialist care, and can after getting a referral-letter, chose a provider all over the country.

The referral letter seems to be more formalised in Sweden and Spain, whereas Ireland and Finland are not using any special Proformas.

In all counties it is not usual to let the patient have an influence on or even decide when the first specialist appointment or the surgery shall take place. From the answers it also seems that the prioritisation process is more formalised in Sweden and in Spain. Interestingly, in Spain the time the patient spent on the list is also something that matters when the scheduling for an appointment or for the surgery is done.

5. Reporting and monitoring waiting times

5.1 Introduction

Information about how waiting times is reported and monitored in the four counties were asked in a special section of the questionnaire. The questions were:

Question 1: How is the waiting time calculated for the purposes of the waiting list statistics?
[E.g. The wait time could be measured retrospectively, showing how many patients were seen in a given time period and how long they waited, or a cross-sectional measurement could be taken to show how many patients were waiting on a given date and the time they had waited]

Question 2: which of the following information is routinely collected?
- *Waiting times for outpatient appointments only*
- *Waiting times for inpatient admission only*
- *Waiting times for the whole process*
- *Neither*
- *Other, please specify*

Question 3: At what level are waiting list statistics reported?
- *National*
- *Regional only*
- *Hospital only*
- *Sickness fund/insurance scheme only*
- *Other, please specify*

Question 4: Is it possible to obtain statistics for the hospitals on the national level for waiting times by:
- *Surgeon* *Yes/No*
- *Procedure* *Yes/No*
- *Specialty* *Yes/No*
- *Other, please specify*

Question 5: Is it possible to obtain statistics for hospitals on the regional level for waiting times by:
- *Surgeon* *Yes/No*
- *Procedure* *Yes/No*
- *Specialty* *Yes/No*
- *Other, please specify*

Question 6: Is reporting of waiting times compulsory? Yes/No

Question 7: Is there any independent body e.g. Patient's Association that monitors waiting times?
Yes/No
If yes, who?

Question 8: Is there any maximum waiting time set for all procedures?

Yes/No

If yes, please explain who sets it, what it is and what happens if a patient waits longer than the maximum wait time.

Question 9: Are there any priority-setting criteria used to select patients for access to all elective surgery?

Yes/No

If yes, please explain

Question 10: Are reasons for patients leaving or being removed from the waiting list recorded?

Yes/No

Question 11: Is there a "suspended" waiting list i.e. a list of patients awaiting elective admission who are not currently available to be called for admission?

Yes/No

What are the criteria for placing someone on the suspended list?

Question 12: Are there any direct incentives to managers, hospitals or doctors for achieving particular waiting time targets?

Yes/No

If Yes, what are they?

Question 13: Are you aware of any major factors that influence the time that people wait for elective surgery in your country?

E.g. geography, age, gender, private financing, type of insurance, lifestyle, social circumstances, ethnic origin.

5.2 Finland

No answer is given to the question of retrospective waiting or cross-sectional statistics for patients on the list. From data delivered to the OECD it seems that the Finnish statistics on waiting times are based on patients admitted, i.e. a retrospective perspective. Also, according to the OECD figures the waiting times for in-patient care are counted from specialist assessment to treatment.

Waiting times are monitored routinely for outpatient appointment and for inpatient admissions respectively. Waiting time or process time for the whole care episode is not monitored.

Waiting times are reported on regional and hospital levels and it is possible to obtain statistics for surgeon, procedure and speciality. This statistics is accessible both for the national level and for the regions.

There are no universal or national priority-setting criteria to select patients for elective surgery.

There is no recording of the reason for patients being removed from waiting lists, and there is no use of "suspended patients list" in Finland.

No answer is given to the question whether the reporting is of waiting times is compulsory or to the question of independent body monitoring waiting lists and waiting times.

In Finland there are no maximum waiting –time guarantees. However, according to the more recent information from OECD there are plans for a guarantee starting in 2005.

Lack of money and saving programmes are mentioned as factors influencing waiting for elective surgery in Finland.

5.3 Ireland

Reporting of waiting times is compulsory in Ireland.

Irelands' waiting list statistics is based on cross-sectional measurement where the number of patients waiting on the list the last day of the month and the length of time on the list are measured. The waiting times are reported in months for the following groups; 0-3, 3-6, 6-12, 12-24, 24-36, 36-48and 48 +.

The only waiting time that is routinely collected is waiting for in-patient admission. Those waiting times are reported nationally and broken down by region, hospital and speciality. It is not possible to get waiting times separated for each surgeon, nor for different procedures. However, it is possible to obtain the information by speciality and separated for adults and children.

In the monitoring of Irish waiting lists the reason for patients' removal from list are not recorded, nor is there a "suspended" list for people who – for the moment – fit for elective surgery.

There are no common criteria for priority-setting in elective surgery, and no independent organisation is monitoring the waiting list situation in Ireland.

There is no Maximum Waiting-time guarantee in Ireland, but in 2001 the government's Department of Health and Children launched a strategy document "Quality and Fairness, A health System for you, Health Strategy. In this document there is a recommendation for waiting time targets. The targets are:

1. By the end of 2002, no patient will have to wait more than 12 months for treatment.
2. By the end of 2003, no patient will have to wait more than 6 months for treatment.
3. By the end of 2004, no patient will have to wait more than 3 months for treatment.

The major factors for waiting lists to elective surgery is

- Lack of beds
- Shortage of medical staff
- Private insurance (usually people with private insurance do not have to wait as long)
- Geography (many people prefer to go to Dublin for surgery
- Emergency Admissions (reduces capacity to undertake elective work)

5.4 Spain

Reporting waiting times is compulsory in the Spanish health care system. In Spain the waiting time statistics is mainly using a cross-sectional measurement at the end of each month. Both the time to an outpatient appointment and time to inpatient admission is recorded routinely.

Waiting lists are reported at the national level and it is possible to obtain the statistics regionally and by hospital for different procedures and specialities, but not for each surgeon.
The same is due for the regional level.

The reason for patients leaving or being removed from waiting lists is recorded in the Spanish statistics on waiting lists. However, there are no "suspended" waiting lists for patients that are not currently available to be called for admission.

There are no priority-setting criteria used to select patients for access to all elective surgery. However, according to the OECD report "Insalud, in collaboration with groups of medical experts, national speciality associations and scientific societies, developed explicit guidelines on clinical prescription or surgical indication criteria for the most frequent waiting list procedures. On the basis of these criteria and guidelines, the patients on the waiting list are supposed to be ranked in two main categories of 'high-priority patients' and routine or low-priority patients'. The priority should be based on clinical factors, such as the underlying disorder, the natural progress of disease, and the degree of disability caused by the disease and the presence of concomitant pathologies. For a given level of clinical condition of patients, priority should be given to the patients that have been waiting for the longest time."

No independent body are watching and reporting the waiting times in Spain.

There is a Maximum Waiting –time guarantee in Spain set out by each regional health service. The maximum waiting time is set to six months, except for cardiac surgery where it is two months. If the waiting time becomes longer the patient can request to be transferred and treated in another hospital.

Social circumstances, lifestyle and geography are mentioned as major factors that influence the waiting time to treatment for elective surgery in Spain.

5.5 Sweden

In Sweden reporting on waiting times is not compulsory. However, beginning year 2000 there is an agreement between the government and the county councils to develop a national database on the Internet for reporting waiting times and waiting lists.

The database is not an individual patient register. Thus the reporting is built on a number of measures that is reported by the county councils three times a year. Waiting times are measured both as retrospective times (% of treated patients that have waited for three months or less, median waiting time and waiting time for 90% of the treated patients), cross-sectional data (number on waiting lists and number on the waiting lists that have been waiting for 12 months or more). The aim of the database is also to inform patients about where they can find the shortest waiting times, therefore the prospective waiting time for new patients are also included in the database.

Included in the database is waiting time to a first visit (from the date when the referral arrives at the hospital unit), and waiting time to treatment (from decision to treat to treatment).

Data is available at both the national and regional level for regions, hospitals, speciality and procedure, but not for each surgeon. The database is not comprehensive, since it only covers a sample of 25 outpatient clinics, seven kinds of investigations and 24 kinds of treatment.

There are no measures of why patients are leaving or being removed from the waiting list. Neither is there a 'suspended' waiting list.
Some of the Associations for people with longstanding illnesses or handicaps do their own monitoring of waiting times in special fields in the health care system.

Sweden has a history of Maximum Waiting–time guarantees dating back to 1992. Today there is a guarantee on the national level for visits in primary care (non-urgent patients should get a visit within seven days and a referral to a specialist should not take more than 90 days). There are plans to introduce a waiting time guarantee of three months for all elective treatment. However, since patients already can chose provider all over the country, a guarantee for treatment will only add an obligation for the 'home' county council to pay for the transport.

There are no explicit criteria for priority-setting when giving patients access to elective care in Sweden. In the middle of the 1990's the Swedish Health Care Act was supplemented with basic rules for priorities in health care. However, these paragraphs do not say anything about priority setting on waiting lists.

Reasons for long waiting times to elective surgery in Sweden can be:

- Increasing demand due to aging of the population, new technologies and widening of indications for surgery.
- Lack of supply of resources due to economy measures and/or lack of skilled personnel.
- Bad management and lack of effective incentives to shorten waiting times

5.6 Summary

All countries, except Sweden, have a compulsory registration of waiting times for elective surgery.

From this brief survey of the way waiting lists are reported and monitored in the different countries it is obvious that it is hard to make any comparisons on waiting times. Finland and Sweden are collecting waiting times for patients that have already been treated, whereas Ireland and Spain looks at the waiting times among patients still waiting on the list. Sweden also collects information about patients on the lists but only the number and percentage of patients that have been waiting for more than a year.

Another weakness is that the way the waiting periods are defined differs quite substantially.

In Sweden it is not possible to get comprehensive information for all patients, since there is only a part of the health care that is covered at the national level. In the other three countries the statistics are based on individual records for all electives. In Ireland however, there is only information about in-patient admissions.

One thing the countries have in common s that there are very few independent bodies that evaluate waiting times and waiting list conditions.

The information to patients differs, probably because of the differences in patients' right to choose hospital. In Sweden the patients easily can get information on the Internet about the actual waiting times all over the country. In Finland this kind of information is available on the regional level in parts of the country.

When it comes to policies to deal with waiting lists the strategies in the different countries seem to be quite alike. All four have some kind of Maximum Waiting-time Guarantee or as it is labeled in Ireland 'recommended waiting time targets'. According to these policies waiting times to treatment should not be longer than three to six months.

Only Spain has up to now developed priority-setting criteria used to select patients for access to all elective surgery.

6. *Comparison of waiting times for three different procedures*

6.1 Introduction

The questionnaire covers three surgical procedures, Cataract removal, Hip-replacement and Coronary Artery Bypass Graft. For each of those patient categories a patient profile (see below) was created in the aim to "track the patient through the system" and be able to compare waiting times for the same basic health care need.

In order to get some information of differences between hospitals this part of the questionnaire was supposed to be answered by three hospitals. However, this was shown to be more difficult than expected, resulting in a various number of answers as is described below.

6.2 Cataract surgery

Only Ireland (three hospitals) and Spain (one hospital) have given a detailed description of the patient pathway for cataracts. These descriptions show that there can be as much variations within countries as between them.

According to the description from three Irish hospitals, the way of becoming a patient due for cataract removal, can vary depending on whom you contact first and the praxis at the hospital where the surgery is done.

The common way to being cared for in the case of patients with cataract is to visit an optometrist or a GP in the first place. The optometrist or the GP sends a referral to a special consultant or a general referral to the eye department at a special hospital. When the referral arrives the data are assessed and the patient is placed on the waiting list for an outpatient appointment. About a week ahead of the examination a letter is sent to the patient with an appointment date for examination, unless the patient has attended an Ophthalmic Medical Practitioner outside the hospital. In those cases the patient is being put on a waiting list immediately.

The patients attends the clinic, they get an examination and will be placed on a waiting list for treatment according to their need. In one of the Irish hospitals there is a visit for biometry, before the decision to treat is actually made. In the other two hospitals the biometry is done as a part of the treatment process after the decision of a cataract removal is made. In one of them it is done the evening before surgery, in the other it is done in the morning of admittance.

In one of the hospitals the praxis is to see the patient two weeks after the surgery, while there is a post-op visit after four weeks at another of the three hospitals. In the third hospital patients are reviewed three(!) times over the two months after surgery.

In the Spanish example the most common pathway is that the patient first visits a GP who sends a referral to an ophthalmologist who examines and diagnoses the patient and sends a referral to the hospital department. Before surgery the patient visits the hospital for a pre-surgery examination. Thereafter the patient is listed for surgery and 1-3 weeks before

the operation the patient will be contacted and a date for the surgery is set. After the operation the patient will be reviewed at two and four weeks.

Patient profile
Cataract removal: OPCS code (s) C71 –C77
ICD (s) for described patient: 366

- Age – 65 years
- Sex- female
- Medically fit
- Cataracts in both eyes
- < 6/12 corrected visual acuity in one eye
- Around 6/9 in other eye
- Suffering from/complaining of glare
- Difficulty in reading small print

Table 6.1: Cataract Removal -Waiting Times (in weeks) for the Sample Patient profile

Hospital	Outpatient visit	Waiting time to treatment
Finland I	50	26
Ireland I	32	4
Ireland II	26	16-52
Ireland III	36	26
Spain I	3 days	4-8
Spain II	3	13
Sweden I	-	26
Sweden II	-	33
Sweden III	-	18

As can be seen in Table 6.1 the waiting times varies substantially both between and within the four countries in this study, even though we have tied to take account of the patient's condition in the profile.

The same pattern is shown when we compare the general waiting times for all patients undergoing cataract surgery (Table 6.2).

Table 6.2: Cataract Removal- General Waiting Times (in weeks).

Hospital	Outpatient visit- Mean Waiting time	Outpatient visit – Range (25%-75%)	Treatment- Mean Waiting time	Treatment – Range (25%-75%)	Source
Finland I	54	12-157	52	4-150	Hospital database
Ireland I	32	30-36	4	3-8	Medical records/Manual files
Ireland II	26	3-26	32	16-52	Consultants'/Admin estimates
Ireland III	26	4-60	26	4-60	Consultants' estimates
Spain I	<1	<1	4-8	-	Hospital Registry
Spain II	3*	1-6*	13	8-17	Database at the hospital
Sweden I	12	-	34	13-53	National Database and Cataract registry
Sweden II	23	-	34	13-53	See above
Sweden III	11	-	19	17-22	See above

*) cross-sectional, May 31, 2002

With reference to the earlier parts of this report it is obvious that the possibility of giving valid and reliable waiting time data differs for the hospitals. For Sweden it has not been possible to give the range of waiting times for those who are waiting a first visit.

In Finland, Spain and Sweden almost all cataract removals is done as day-surgery. However, in Ireland the vast majority of patients are treated as in-patients with an average length of stay of 2-3 days.

Only Finland has given a positive answer to the question of the existence of national guide-lines for placing patients on waiting list for cataract removal. According to the answer the limits are made up of a measure of visual acuity and a quality of life measure (vf-70).

In Spain there exists general guidelines for placing patients on waiting lists, but there are no special conditions for cataracts. Spain is also the only country with a maximum waiting time guarantee (6 months) for treatment of cataracts.

6.2 Primary hip replacement

Data for hip replacements has been supplied for one hospital in Finland with a yearly production of approx. 110 replacements, three Irish hospitals with approx. 3-400 replacements a year, two Spanish hospitals with 350-400 replacements a year and two Swedish hospitals with a yearly production of 200-250 replacements.

Patient profile:
Hip Replacement: OPCS code(s) W37-39 and? ICD(s) for described patient: 715

- ge – 65 years
- Sex- female
- Osteoarthrosis
- Moderate pain, including pain at night
- Taking analgesia regularly
- Reduced range of movement
- Antalgic gait

The path-way for the sample patient with a bad hip is described below for one of the Swedish hospitals.

1. General Practitioner;
2. Referral to physiotherapist for assessment and prioritisation, X-ray possibly taken. Patent referred to;
3. Consultant outpatient clinic and placed on waiting list (3-6 months)
4. Patient attends outpatient clinic at which the patient undergoes examination, X-ray if required, basic health check, and physiotherapy advice
5. Patient listed for surgery (as routine, soon or urgent). Patient waits (1-12 months). Date for surgery notified to patient four weeks before operation (by letter).
6. Nurse-pre-anaesthetic assessment two weeks before operation. Discharge planning involving physiotherapist and occupational therapist.
7. Patient attends, operation carried out.

Not unexpectedly, this scheme for a hip-replacement procedure have much in common with the path-way reported from the three Irish and one of the Spanish hospitals. However, the second step with assessment by a physiotherapist seems to bee exclusively practiced at the Swedish hospital.

Another difference between the hospitals is that at in the Spanish and one of the Irish hospitals the GP referral is first sent to a local outpatient clinic or specialist for assessment. Thereafter is a referral sent to the hospital for a new outpatient visit and assessment before the surgery is performed.

Table 6.3: Hip replacement - Waiting Times (in weeks) for the Sample Patient profile

Hospital	Outpatient visit	Waiting time to treatment
Finland I	24	24
Ireland I	52+	24-36
Ireland II	24-36	12-78
Ireland III	-	-
Spain I	4	16
Spain II	3	13
Sweden I	12	48
Sweden II	12-26	4-52

Like in the case of cataract removal, there are great variations in waiting time for a patient with the same conditions. The Spanish waiting times are again the lowest.

Table 6.4: Hip replacement - General Waiting Times (in weeks).

Hospital	Outpatient visit- Mean Waiting time	Outpatient visit – Range (25%-75%)	Treatment- Mean Waiting time	Treatment – Range (25%-75%)	Length of stay in days	Source
Finland I	20	16-24	20	12-28	6	-
Ireland I	52+	4-322	32-40	6-104	12	Consultants' Estimate, Medical records/Manual files
Ireland II	35	22-52	12-26	12-78	10-14	Consultants'/Admin estimates, computerised files
Ireland III	28	1-156	12-26	12-156	15	Administrative Staff, computerised files
Spain I	2	-	16	-	-	Hospital Registry
Spain II	2*	1-6*	13	7-19	15	Database at the hospital
Sweden I	12	48	10	6-20	6	Estimates
Sweden II	12-26	4-52	27	14-43	6	-Hospital information system

*) cross-sectional, May 31, 2002

There are no recommendations or guidelines for either putting a patient on the list or for prioritising patients on the list. Priority categories are mostly urgent, semi-urgent or non-urgent. In one of the Swedish hospitals the priority is given as a time-span.

Only Spain has a Maximum Waiting time Guarantee (6 months).

6.3 Coronary Artery Bypass Graft (CABG)

CABG is highly specialised care and therefore only performed at a few special hospitals in each country. In this study we have only managed to gather valid information from one Irish and one Spanish hospital. In the Irish hospital patients are referred to another hospital if they need a CABG. The same is due for the Finnish hospital, and from this hospital we only have got partial information about the waiting times.

The patients' way to a CABG is described in the following terms from the Spanish hospital.

1. General practitioner refers using a referral form
2. Cardiologic clinic in peripheral outpatient area diagnoses the patient and refers to Hospital Cardiologic Department (there are specific guidelines elaborated by the different specialized medical associations).
3. Patient attends outpatient clinic and undergoes physical examination and the examinations required. At the end of the diagnostic phase the case is considered by a group of experts. Patient is placed on a waiting list for CABG.
4. Patient listed for surgery

   Priority is given according to the following groups:
   Urgent
   Code 0 – less than 24 hours
   Code 1 – less than 72 hours
   Code 2 – less than 14 days

   Routine
   Code 3 – less than 6 weeks
   Code 4 – less than 3 months
   Code 4 – less than 9 months

5. Date for surgery arranged 1-2 weeks before operation date by telephone by secretary
6. Patient attends, operation carried out

Patient profile

Coronary Artery Bypass Graft:
- Sex- male
- Unstable angina (Class III)
- 3VD, 75% proximal LAD
- Positive exercise test

In the Spanish hospital a patient with the profile as above have to wait approx 2 weeks for the outpatient appointment at the hospital and 3-4 weeks on a waiting list for surgery.

In the Irish hospital the waiting time for an outpatient visit is 8 weeks, but here the patients are referred directly from the GP to the Cardiac Outpatients. The waiting time to surgery is 12 weeks in the Irish hospital.

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2. Sanmartin, C. A. Toward Standard Definitions for Waiting Times, Health Care Management Forum.
3. Löfvendahl S., Hellberg S.,Hanning M., Study on Prioritisation of Referrals in Orthopaedic Care (English summary), Journal of the Swedish Medical Association (Läkartidningen) 2002:99(17):1931-9.
4. Cataract: how much surgery do we have to do? Editorial. British Journal of Ophthalmology, 2000; 84:1-2.
5. Swedish Federation of County Councils, (in press)

Ministerio de Sanidad y Consumo, Technical Report on Waiting List, Waiting list Expert Group, Madrid 2002.

Annex 1

This text is quoted from: Waiting Times for Elective Surgery. Final Report of the OECD Waiting Times Project. 21-Nov 2003.

RECOMMENDATIONS FOR FURTHER RESEARCH AND FOR DATA COLLECTION

130. One of the main obstacles to improving the efficiency of the public provision of surgery, and to achieving optimal waiting times, is the fog of uncertainty which surrounds the phenomenon. There is both 'clinical uncertainty' and 'policy uncertainty'.

131. One aspect of this fog is the comparative lack of evaluation of effectiveness in the field of surgery. There are difficulties in conducting clinical trials for new procedures. Nevertheless, there should be more evaluation of new and old techniques. There may well be scope for more international cooperation, here, as in the field of pharmacoeconomic assessment (Dickson et al, 2003).

132. Allied to the question of evaluation, is that of guidelines and priority scoring of patients. Priority scoring systems such as those developed in Canada and New Zealand are needed to make the clinical and social consequences of rationing clearer at the margin to patients, surgeons and policy makers. That should help equity as well as resource allocation decisions at the macro and micro levels.

133. Similarly better information is needed for benchmarking levels of elective surgery both within and between countries. The data available at international level on surgery (particularly day surgery) rates is full of gaps, especially for some countries which appear to have demand-led programmes. That is surprising in view of the fact that these countries often have the more severe problems with cost containment. Data is also lacking on inputs to the surgical process such as surgeons, theatre nurses, surgical inpatient beds and surgical day case beds. Consequently there is almost no possibility of making international comparisons of productivity for these expensive and growing services. Coupled to this, is a lack of evidence on prices and costs of surgery across countries.

134. Finally, in publicly funded health systems where, for very good reasons, price signals have been suppressed, waiting times for elective surgery can provide alternative signals about the size of excess demand, subject to some 'noise' arising from different propensities to generate waiting. There would seem to be merit in extending the possibility for international benchmarking of waiting times. This project has shown that reasonably comparable data on waiting times are now available for 7 or 8 member countries for at least 10 procedures, from administrative sources. The measure which seems to be most widely available is the mean waiting time of the patients admitted to surgical units, measured from the time that patients are put on the waiting list. Several other countries might be able to provide similar data at moderate cost with only modest modifications to their existing data collection

methods. An alternative approach would be to commission sample surveys of, say, ex-surgery patients in a wider range of countries, asking them about their experience with waiting. The possibility of obtaining such data in a few countries has been demonstrated by the Commonwealth Fund Surveys (Table 2, above).

Recommendations for policy

135. Some countries seem to be presiding over open-ended, demand-led (or surgeon-led) public surgery programmes with high rates of surgery and negligible waiting times. Others are tightly constraining supply, judging by their low rates of surgery and *average* waiting times for some elective conditions that exceed 6 months. These macro and micro variations suggest that there are major opportunities in the OECD area to improve both the efficiency and the equity of the provision of surgery within public programmes.

136. This study has suggested that if countries find that they have excessive waiting times and they consider that their surgery rates are too low that they can bring down waiting times by sufficient increases in surgical capacity. However, such an approach will incur high costs – expansion at long run marginal costs which are likely to be at or close to long run average costs. Moreover, such countries may have two mountains to climb – given the secular rise in demand for surgery, which appears to affect all countries.

137. For countries that have been paying their hospitals by global budgets and their surgeons by salaries, they are likely to be able to increase their surgery rates and bring down waiting times by introducing an element of activity-related payment for hospitals and surgeons. However, that is likely to achieve only a one-off improvement in efficiency and unless measures are taken to require providers to pass on the efficiency gains in the form of lower prices, costs to the public programme may rise as much as under capacity enhancement. Moreover, under activity-related payment, surgical expenditure may be more difficult to forecast and control. Efficiency gains may also be possible by further switching procedures to day surgery, where appropriate.

138. If waiting times are regarded as excessive, yet the public supply of surgery is judged to be adequate, or as much as the government is prepared to fund, then waiting times can be brought down by changing the propensity to generate waiting, in effect by tighter management of demand, as in New Zealand, or by financial incentivisation of providers to shorten queues, as in Spain. A great attraction of such policies is that they can impact waiting times at low cost, once the cooperation of surgeons and providers has been obtained. They may lead to care taking place at the most appropriate level in the health care system. However, a possible disadvantage of such policies is that if they are misjudged, they may suppress waiting time signals that convey information about the underlying state of excess demand for surgery.

139. An alternative approach is to impose maximum waiting time targets (such as, 'no patients should wait longer than one year') but these are likely to clash with clinical priorities unless they are based on an agreed clinical priority scoring system, as in New Zealand. Moreover, when they are applied, they seem to be like squeezing a balloon – long waits go down but short waits (those with the highest clinical priority) go up.

140. Yet another alternative is to encourage, or even to subsidise, private health insurance with the intention of bringing down demand for public surgery. However, unless there is spare capacity, such subsidies may lead to resources being sucked out of the public system, with disappointing results for public waiting times, at least in the short term.

141. Finally, given the divergence between public opinion and patient experience of waiting times, reported at the end of the Conclusions, above, there may well be a case for some governments to invest in better education of the public about the costs and benefits of waiting for elective surgery.

Reference:

Dickson, M et al., 2003, Survey of Pharmacoeconomical Assessment Activity in Eleven Countries". OECD, Health Working Papers, n 4.

Annex 2

Chart A7. Waiting times and surgical activity: hip replacement. Year 2000

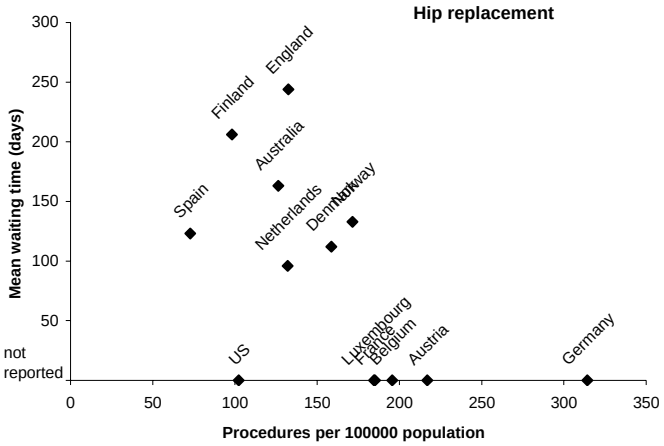

Chart A8. Waiting times and surgical activity: inguinal and femoral hernia. Year 2000

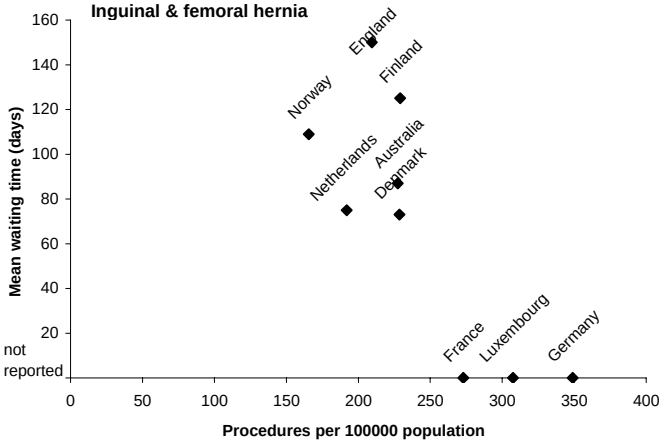

Chart A9. Waiting times and surgical activity: varicose veins. Year 2000

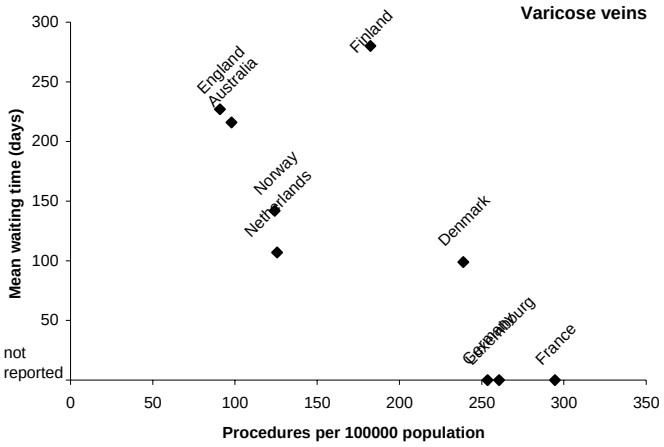

Chart A10. Waiting times and surgical activity: cholecystectomy. Year 2000

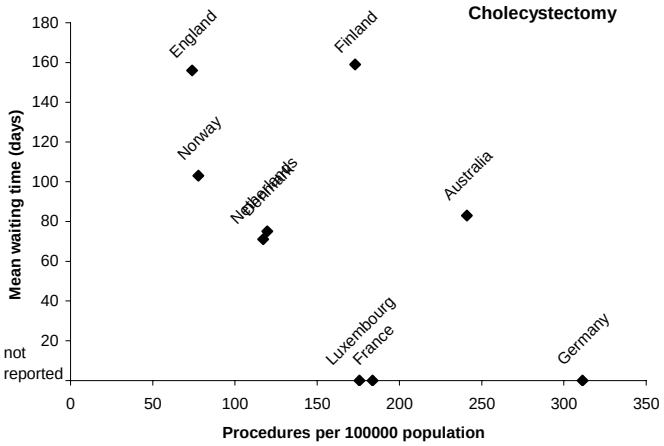

Chart A11. Waiting times and surgical activity: prostatectomy. Year 2000

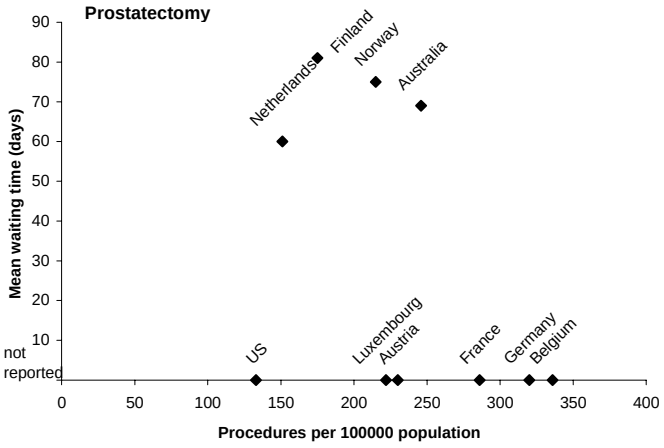

Chart A12. Waiting times and surgical activity: hysterectomy. Year 2000

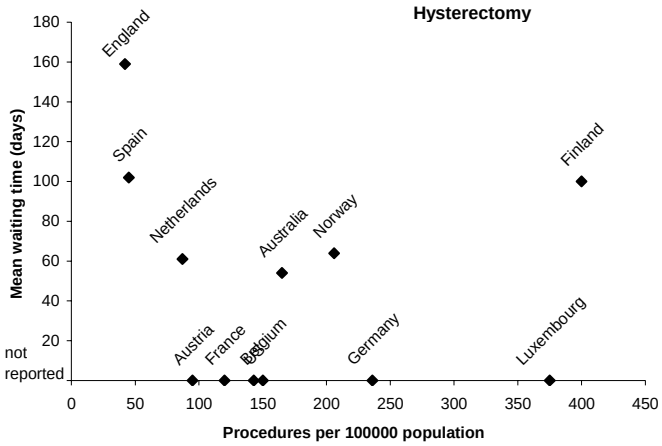

Chart A13. Waiting times and surgical activity: cataract surgery. Year 2000

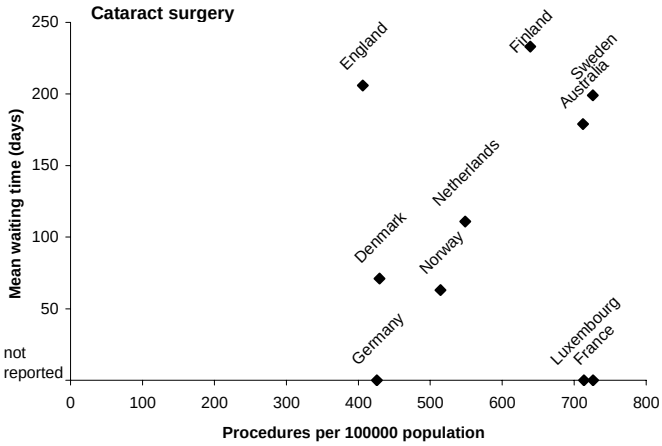

Chart A14. Waiting times and surgical activity: knee replacement. Year 2000