Waiting Time Policies in the Health Sector: *What works?*  

Luigi Siciliani  
Department of Economics  
*University of York*  

The Taming of the Queue  
Ottawa  
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Outline

• Waiting time policies. What works?  

• Measures of waiting times across the OECD  

• Waiting time inequalities and socioeconomic status
Reviews various policy tools that countries have used to tackle excessive waiting times in 13 countries

- Australia
- Canada
- Denmark
- Finland
- Ireland
- Italy
- Netherlands
- New Zealand
- Norway
- Portugal
- Spain
- Sweden
- United Kingdom
Second OECD waiting time project

• **Second** OECD waiting time project:
  – Better empirical evidence
  – Some policies that “work”
  – Some new ideas, some old ones

• **First** OECD waiting time project, 2001-2004:
  – More difficult to gather empirical evidence
  – Lower quality of waiting time data
  – Not many policies that “work”
  – Summarised in Siciliani & Hurst (2005), *Health Policy*

A 1-slide summary

• Most common policy:
  – some form of *maximum* waiting time guarantee

• Implementation and use can be quite different
  – **Target** (increasingly with sanctions): England, Finland
  – With **choice**, competition (and private sector):
    Denmark, Netherlands, Portugal
  – **Prioritisation**: New Zealand (and Canada) plus others

• Increasingly, **max waits** are differentiated for specific conditions such as **cancer**, **heart** conditions
A key message

• Supply policies are no guarantee of success

• They can work only if demand is kept under control

• The latter may be implemented through wait targets (data are now good enough)

Policies that “work”

• There are plenty of policies that do not work to reduce waiting times

• I will focus on policies that “work”

• What “works” is narrowly defined as reductions in waiting
## A brief summary

### Table 3.1. Frequency of use and potential effect of policies to address waiting times

<table>
<thead>
<tr>
<th>Policies</th>
<th>Commonly used</th>
<th>Potential effect on waiting times</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supply-side policies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Increased production in the public sector by funding extra activity</td>
<td>6/13 countries</td>
<td>Weak</td>
</tr>
<tr>
<td>2. Contracting with private sector</td>
<td>6/13 countries</td>
<td>Weak</td>
</tr>
<tr>
<td>3. Sending patients abroad</td>
<td>3/13 countries</td>
<td>Weak</td>
</tr>
<tr>
<td>4. Increased productivity by introducing activity-based financing (DRGs)</td>
<td>3/13 countries</td>
<td>Medium</td>
</tr>
<tr>
<td>5. Increased choice of providers</td>
<td>5/13 countries</td>
<td>Medium</td>
</tr>
<tr>
<td>6. Improved management of waiting lists</td>
<td>5/13 countries</td>
<td>Medium</td>
</tr>
<tr>
<td><strong>Demand-side policies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Explicit guidelines to prioritise patients</td>
<td>7/13 countries</td>
<td>Medium</td>
</tr>
<tr>
<td>2. Subsidise private insurers</td>
<td>5/13 countries</td>
<td>Weak</td>
</tr>
<tr>
<td><strong>Combined policies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Waiting-time guarantees</td>
<td>13/13 countries</td>
<td>Weak</td>
</tr>
<tr>
<td>2. With sanctions</td>
<td>3/13 countries</td>
<td>Strong</td>
</tr>
<tr>
<td>3. With choice and competition</td>
<td>6/13 countries</td>
<td>Strong</td>
</tr>
</tbody>
</table>

Source: Based on OECD Secretariat assessment of 13 case studies and review of the literature.

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ENGLAND
Maximum waiting times guarantees
England 2000-2005

- Can you reduce waiting times by enforcing waiting-time targets and tough penalties?

- Penalties: higher chance of hospital managers from losing their jobs: ‘targets and terror’; (Propper et al. 2008)
Patients’ entitlements (England)

- **NHS Constitution** (2010): “You have [the patient has] the right to access services within maximum waiting times,...”

- Maximum wait from GP referral to treatment of **18 weeks** (known as “referral to treatment” (RTT))

- DH expects **90% of patients** to be treated **within target**

- Breach of these targets results in a **reduction of up to 5% of revenues** for the relevant speciality in the month in which the breach occurs
Health care guarantee 2005

• Primary care services: within 3 days

• Patients referred to a specialist: 3 weeks (including diagnostics)

• If surgery is needed: within 6 months of the assessment of the need for care/treatment

• Number of patients waiting over 6 months decreased from 126 to 66 per 10 000 population between 2002-2005
Figure 7.1. Number of patients waiting longer than 180 days for specialist care per 10,000 inhabitants, Finland, October 2002 to April 2011

Mean number of patients per 10,000 inhabitants


StatLink: http://dx.doi.org/10.1787/888932754084

Figure 7.4. Cataract surgery in public health care, Finland, 2001 to 2010

All procedures


StatLink: http://dx.doi.org/10.1787/888932754141
Valvira

• Critical role played by Valvira, the National Supervisory Agency

• Authority to penalise municipalities that failed to comply

• Valvira provided targets to municipalities for progressive reductions

• By 2010 almost all the hospital districts met the targets

• But Valvira had to issue 30 orders for improvement, including eight with a threat of fines

• “Rubber band”: any time the supervisory regime was lessened, waiting times increased

DENMARK
Choice, choice, choice...

- **1993**: Free choice of hospital: *max wait* 3 months from GP or specialist referral to treatment

- **2002**: 2 months; wait guarantee (not in a legal sense)

- **2007**: 4 weeks regardless of disease or severity
**Choice, choice, choice...**

- If hospital cannot (foresee to) fulfil max wait, patients can **choose** another **public** or **private** hospital

- If **outside** of region’s own hospitals, expenses covered by region (no patient travelling expenses)

- % of patients in commercial **private** hospitals up from 2% to 4.2% in 2006-2008 and 4.8% in 2010

- Expected max wait **declined** significantly after 2002, and it is believed that free choice played an important role

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**But not only choice: payment rules**

- From **2000**: counties paid the **DRG tariff** (ie average cost of receiving county):
  - **profitable to keep patients within the county or attract patients from other counties**

- Until **1999**: each Danish county treating patients from another county received a **low per-diem** from other county
Figure 6.1. Expected and experienced waiting time for various treatments, Denmark, 1998 to 2011

Note: Cancer surgery: unweighted average of waiting time for 11 cancer diagnoses; chemotherapy: unweighted average of waiting time for 18 cancer diagnoses; radiation therapy: unweighted average of waiting time for 18 diagnoses.
1. Including waiting time for pre-examination.

http://dx.doi.org/10.1787/888932754065

NETHERLANDS
### Table 5.4. Mean inpatient waiting times of patients admitted by surgical procedure, 2000

For eight countries where waiting times are reported to be a policy concern.

Number of days

<table>
<thead>
<tr>
<th></th>
<th>Hip</th>
<th>Knee</th>
<th>Cataract</th>
<th>Various veins</th>
<th>Hysterectomy</th>
<th>Prostatectomy</th>
<th>Cholecystectomy</th>
<th>Inguinal and femoral hernia</th>
<th>CABG</th>
<th>PTCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>163</td>
<td>201</td>
<td>179</td>
<td>245</td>
<td>54</td>
<td>69</td>
<td>83</td>
<td>87</td>
<td>44</td>
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<tr>
<td>Denmark</td>
<td>112</td>
<td>112</td>
<td>71</td>
<td>99</td>
<td>75</td>
<td>75</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>206</td>
<td>274</td>
<td>230</td>
<td>289</td>
<td>100</td>
<td>81</td>
<td>159</td>
<td>125</td>
<td>42</td>
<td>29</td>
</tr>
<tr>
<td>Norway</td>
<td>133</td>
<td>160</td>
<td>63</td>
<td>142</td>
<td>64</td>
<td>75</td>
<td>103</td>
<td>109</td>
<td>46</td>
<td>63</td>
</tr>
<tr>
<td>Netherlands</td>
<td>96</td>
<td>84</td>
<td>111</td>
<td>107</td>
<td>61</td>
<td>60</td>
<td>71</td>
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<td>18</td>
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<tr>
<td>Spain (insured)</td>
<td>123</td>
<td>148</td>
<td>104</td>
<td>117</td>
<td>102</td>
<td>62</td>
<td>107</td>
<td>102</td>
<td>39</td>
<td>81</td>
</tr>
<tr>
<td>Sweden</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>199</td>
<td></td>
</tr>
<tr>
<td>United Kingdom (England)</td>
<td>244</td>
<td>201</td>
<td>206</td>
<td>227</td>
<td>159</td>
<td>52</td>
<td>156</td>
<td>150</td>
<td>213</td>
<td>89</td>
</tr>
</tbody>
</table>

**Note:** More details on "Source and method" are contained in Annex 2 of Siciliani and Hurst (2003). Australia: includes Queensland, South Australia and Western Australia. Norway: cataract waiting time refers to 2001. Spain: includes INSALUD population only. United Kingdom: includes English population only. Source: OECD.

Hurst and Siciliani, 2004

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### Table 10.4. Mean waiting time of patients admitted by surgical procedure in Dutch hospitals, 2000 to 2011

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract surgery</td>
<td>18</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Various veins</td>
<td>15</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip replacement</td>
<td>14</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee replacement</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inguinal and femoral hernia</td>
<td>11</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>10</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostatectomy</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTCA</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td></td>
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<tr>
<td>CABG</td>
<td>n.a.</td>
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</tr>
</tbody>
</table>

1. Including out-patient care (day-case treatment) and in-patient care (> 24 hour admission). Due to a change in waiting time definitions in 2005, waiting time data before and after 2005 may not be fully comparable (see Box 10.1).
2. Defined on the basis of Dutch diagnosis treatment combinations (DTCs).


Source: http://dx.doi.org/10.1787/88893255129
What happened?

• 1990s: Waiting times salient political issue
  – Significant targeted funds, but waits remains
  – Why? Possibly, cap on hospital spending

• Early 2000: government considered max wait guarantee (court decision in 1999: patients have enforceable right to timely care)
  – Not introduced because of concerns over making this operational

Treek norms: socially acceptable waiting time (year 2000)

• Therefore not a guarantee

• 4 weeks (80% within 3 weeks) for hospital specialist diagnosis and medical assessment

• 6 weeks (80% within 4 weeks) for day treatment

• 7 weeks (80% within 5 weeks) for inpatient treatment
... though not only ‘norms’

• 2001: hospital fixed budget scheme replaced with activity-based payments (known as a “cash on the nail” scheme)

• Abolished restrictions on n. of medical specialist positions in hospitals

• 2008: specialist remuneration changed from lump-sum payments per hospital to output-based payments per DBC
  – Hospital and specialist incentives now aligned
  – Hospital production increased rapidly
  – Combination of relatively soft guarantee linked to choice with competition linked to activity-based financing

But...

• Total health care expenditure has rapidly increased
  – Evidence that extra resources not spent efficiently

• Waiting lists no longer an important policy concern today

• Policy makers primarily concerned with rapid growth in HE
  – strong incentives for hospitals & specialists to raise production
  – limited countervailing power of health insurers
PORTUGAL

<table>
<thead>
<tr>
<th>Year</th>
<th>Hip procedures</th>
<th>Hernia</th>
<th>Veni ligation</th>
<th>Carpal tunnel release</th>
<th>Eye procedures</th>
<th>Cholecystectomy</th>
<th>CABG</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>137.53</td>
<td>103</td>
<td>253.78</td>
<td>122.98</td>
<td>196.01</td>
<td>147.61</td>
<td>99</td>
</tr>
<tr>
<td>2007</td>
<td>147.97</td>
<td>108</td>
<td>222.25</td>
<td>137.84</td>
<td>172.10</td>
<td>142.86</td>
<td>92</td>
</tr>
<tr>
<td>2008</td>
<td>136.50</td>
<td>90</td>
<td>201.74</td>
<td>127.63</td>
<td>101.40</td>
<td>123.90</td>
<td>56</td>
</tr>
<tr>
<td>2009</td>
<td>124.73</td>
<td>72</td>
<td>182.72</td>
<td>94.29</td>
<td>73.14</td>
<td>127.30</td>
<td>57</td>
</tr>
<tr>
<td>2010</td>
<td>138.90</td>
<td>105</td>
<td>167.47</td>
<td>98.66</td>
<td>71.86</td>
<td>115.46</td>
<td>79</td>
</tr>
</tbody>
</table>

Integrated Management System of the Waiting List for Surgery (SIGIC)

- Combination of wait guarantees with **new integrated information system** to collect wait for public & private hospitals

- **Feature: voucher** to operationalise waiting time guarantee
  - *When patient on the list reaches 75% of max guaranteed wait, voucher is issued*
  - *Voucher allows to seek treatment at any provider, including private sector*

- Incentives for public hospitals to treat within the waiting time guarantee (but no “terror”)

![Impact of SIGIC on waiting lists and waiting times in Portugal](image_url)
**New Zealand: Booking system**

*Three groups*

- **Booked**, treatment within 6 months
- **Certainty of treatment** within 6 months (added to the list)
- **Active care and review** (not added to the list), sent back to GP

- Max wait time *conditional* on belonging to booked/certainty of treatment

- Patient’s *entitlement* depends on need and ability to benefit as assessed by the specialist (*within 6 months from referral*)

- Patients in Active care can be reviewed if health deteriorates

- **Prioritization tools (CPAC)** used to help specialists to assess need and ability to benefit consistently (similar to some Canadian experiences)
Norway: Individual max wt time

Three groups of patients

• 1. Emergency
• 2. Elective with individual maximum waiting time
• 3. Elective without maximum waiting time

• Assessment of patient condition determined on the basis of
  – Degree of severity
  – Expected efficacy of treatment
  – Cost in relation to expected outcome of treatment

• If patient in group 2, hospitals provide max wt time, over which the patient can
  – (i) file a complaint (though very few do)
  – (ii) hospital has 2 weeks to fulfil
  – (iii) be treated in a different hospital (public or private) billed to the originating hospital

Conclusions on wait policies

• Several new policies that ‘work’

• Extensive use of maximum waits
  – specified in different ways and integrated with other policies

• Wide range of demand- and supply-side policies
A dilemma on guarantees

- **Unconditional** (same for everyone)
  max waiting time guarantees are:
  - *easy to operationalise*
  - *contradict prioritisation*

- **Conditional** (on severity, benefit or other)
  max waiting time guarantees are:
  - *difficult to operationalise*
  - *do not contradict prioritisation*

Limitations

- “what works” narrowly defined as reductions in waiting

- Empirical evidence descriptive (establish causality)

- Side effects? Does excessive focus on waiting distract from real issues (health outcomes)?
Measures of waiting times across OECD countries

Siciliani, Moran and Borowitz (2014) Health Policy

Key issues

• When does the waiting time start?
  – Specialist visit/assessment
  – Family doctor referral (referral-to-treatment)

• At what level?
  – Surgical procedure
  – Speciality

• Complete versus incomplete wait
  – Wait for patients treated
  – Wait for patients on the list
Patients treated versus patients on the list

![Diagram showing patients starting to wait at different times and different time intervals.]

Four possible measures across OECD

- **Inpatient** waiting times (from specialist addition to the list) of patients treated in a given year
- **Referral-to-treatment** waiting times (from family doctor referral) of patients treated in a given year
- **Inpatient** waiting times (from specialist addition to the list) of patients on the list at a census date
- **Referral-to-treatment** waiting time (from family doctor referral to treatment) of patients on the list at a census date
Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract surgery</td>
</tr>
<tr>
<td>Percutaneous transluminal coronary angioplasty (PTCA)</td>
</tr>
<tr>
<td>Coronary bypass</td>
</tr>
<tr>
<td>Cholecystectomy (includes the revision of prior partial cholecystectomy)</td>
</tr>
<tr>
<td>Inguinal and femoral hernia</td>
</tr>
<tr>
<td>Prostatectomy</td>
</tr>
<tr>
<td>Vaginal hysterectomy</td>
</tr>
<tr>
<td>Knee arthroscopy with meniscus repair</td>
</tr>
<tr>
<td>Total and partial hip replacement (includes the revision of hip replacement)</td>
</tr>
<tr>
<td>Knee replacement (includes the revision of knee replacement)</td>
</tr>
<tr>
<td>Ligation and stripping of varicose veins (includes veins of the lower limb</td>
</tr>
</tbody>
</table>

Inequalities in waiting times by socioeconomic status
Waiting time and SES

• Extensive policy focus on prioritisation

• Waiting times are equitable

• Co-payments/co-insurance often perceived as inequitable

• Some empirical evidence tests whether patients with higher income/education wait less within publicly-funded systems

Some existing evidence

• Norway
  – Monstad et al. (2014, HE) for hip replacement patients: negative association between income (education) and wts for men (women), about 12% difference

• Sweden
  – Tinghög et al. (2014, IJHSR): individuals with low income experience longer waiting times for orthopedic (27%) and general surgery (34%)

• Australia
  – Johar et al. (2013, JHE) New South Wales: 2 to 3 months delays favouring most wealth-advantaged groups
  – Sharma et al. (2013, EcMod) Victoria: patients from richest areas waiting about 12% less compared to those from poorest ones
Some existing evidence

- **England**
  - Cooper et al (2009, BMJ)
  - Patients in the most *income*-deprived quintile wait about 7% longer than patients in the least deprived quintile

- Evidence above from administrative data

- Some evidence from survey data as well
  - Siciliani and Verzulli (2009) using SHARE (survey for elderly Europeans)
  - For specialist consultation, individuals with high education experience a reduction in waiting times of 68% in Spain, 67% in Italy and 34% in France (compared to low education)

Explanations

- Individuals with higher SES may have better social networks
- May engage more with the system exercising pressure as they experience delay
- Lower probability to attend hospital admission, increasing the duration of their waiting time
- Results have possible implications for waiting list prioritisation
For more information


• Email: luigi.siciliani@york.ac.uk

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