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Waiting time prioritisation for specialist services in Italy: The homogeneous waiting time groups approach

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ABSTRACT

The demand for referrals and diagnostic procedures in Italy has been rising constantly in recent years, making access to diagnostic services increasingly difficult with significant waiting times. A number of Health Authorities (known as Local Health Units) have responded by implementing formalised waiting-time prioritisation tools, giving rise to what are known as Homogeneous Waiting Groups (HWGs). The study describes the implementation of the HWG approach in Italy. This represents a promising tool for improving the prioritisation of patients waiting to see a specialist or to receive a diagnostic test. The study of the Italian HWG experience provides useful insights to improve the outpatient referral process for those countries where the demand prioritisation policies have focused more on inpatient care than outpatient specialist care and diagnostic services.

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1. Introduction

The management of waiting lists is an acknowledged health policy issue in several OECD countries [1]. Traditionally, the focus has been on inpatient waiting times (the time from specialists' addition to the list to the time of treatment). The focus has recently shifted to the wait from general practitioner (GP) referral to diagnosis, consequently including the wait from GP referral to specialist examination, i.e. the 'outpatient' waiting time.

Like in other OECD countries, the demand of referrals for specialist visits and diagnostic procedures in Italy has been rising in recent years, making access to these services difficult [2]. A recent survey suggests that patients experience excessive waits to access outpatient specialist care provided by Health Authorities (known as Local Health Units, LHUs) in many Italian regions [3]. In Italy, waiting time appears more critical for outpatient specialist care and diagnostic services than for elective inpatient admissions. To address this issue, most Italian regions have improved patients' access through better information management of waiting times, process re-engineering and the creation of unified booking centres. Diagnostic and therapeutic pathways are also well established in several regions [4,5]. Recently, prioritisation criteria have been piloted to manage outpatient waiting times based on clinical criteria and professional judgement.

Access to outpatient specialist care and diagnostic services on a "first-come, first-served" approach is neither equitable nor efficient, because patients differ substantially in their clinical needs [6]. Clinical prioritisation is a form of waiting time management, based on the idea of setting shorter waiting times for patients with higher clinical needs, and longer waiting times for patients with lesser needs. Prioritisation can improve both the effectiveness (patients who need a timely access to care reduce their risk of a health decay) and the equity of access to health care (patients' access is based on the priority of their needs) [7,8]. Moreover, it can improve the transparency of waiting list management (adoption by health professionals of explicit and shared criteria) and on efficiency of health care provision (reducing congestion and accumulated backlog) [9].

Prioritising patients on waiting lists is usually carried out in two ways: (i) assigning a priority score to each patient; (ii) segmenting the waiting list through the categorization of patients into a number of priority classes with different service time target. The former has generally shown a stronger reliability for elective surgery and a weaker performance for diagnostic services and outpatient specialist care [10].

The implementation of clinical prioritisation is difficult since it requires detailed reviews of the evidence, and it is more complex for diagnostic services than for therapeutic ones. Hadorn and colleagues [11], considering diagnostic MRI procedures, have shown that assessing relative urgency is complicated by the need to estimate the likelihood that the procedure will provide critical diagnostic information and that subsequent treatment will improve health outcomes. In addition, evidences and recommendations on the appropriate and timely access to outpatient services are mostly available for some instrumental procedures [12,13] while are rather scanty for other specialist services. As a consequence, when little empirical evidence is available, extensive involvement and cooperation between GPs and specialists is needed to improve the outpatient referral process, prioritising the delivery of outpatient care on the basis of clinical appropriateness and patient severity. To this aim, two strategies in the primary–secondary care interface are recommended: (i) the involvement of specialists in educational activities and (ii) the enhancement of communication among physicians through the dissemination of guidelines with structured referral sheets [14].

Demand management through priority scores represents a widespread policy to face excessive waiting times especially for elective inpatient services [9]. An effective management of waiting lists for outpatient services should call for a prioritisation process in which GPs and specialists co-operate and agree upon the definition of clinical criteria for timely referrals. However, even though rather promising, this particular prioritisation policy, involving both GPs and specialists, is adopted less frequently. In the UK attempts have been made to define timely referrals for some disorders [15] and to manage patients with suspected cancer [16–18]. In Canada 24 statements based on a wide consensus have defined clinically acceptable waiting times for digestive disorders [13]. In New Zealand, Access Criteria for First Specialist Assessment (ACA) were developed in the late 90s for some diagnostic procedures (e.g., gastroscopy and colonoscopy) [19,20]. A similar approach was used in New South Wales in the mid-90s for elective surgery admissions [21,22]; patients without high priority level were considered "staged patient": they were staged on clinical grounds but did not lose their place on the hospital queue.

This kind of approach of waiting list prioritisation for outpatient health services has been adopted in Italy since the end of 90s, involving some LHUs. It is based on the implementation of Homogeneous Waiting Groups (HWGs) agreed upon by GPs and specialists who are involved in the definition of clinical criteria for timely referrals. According to the HWG approach clinical conditions are linked to maximum waiting times according to a quantitative ranking (priority classes) [23]. The main goal of the HWG approach is to redistribute out-patient referrals on the basis of clinical priority. It does not necessarily reduce the demand for referrals, eliminating those deemed inappropriate. Rather it determines a concentration of inappropriate demand in low-priority (deferrable) referrals [24–26].

The present contribution provides a detailed analysis of the HWG approach first implemented in Italy by a pilot health care agency (in the LHU of the Autonomous Province of Trento) which had a leading role in shaping the design, the development and the diffusion of the HWG approach to other Italian regions and LHUs. The study highlights the strength of the adopted prioritisation approach to guarantee an efficient, transparent and equitable access to outpatient care. Moreover, the study provides useful insights to improve the outpatient referral process for those countries where demand prioritisation policies have