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Tackling excessive waiting times for elective surgery: a comparative analysis of policies in 12 OECD countries

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Abstract

This paper compares policies to tackle excessive waiting times for elective surgery in 12 OECD countries. It is found that waiting times may be reduced by acting on the supply of or on the demand for surgery (or both). On the supply side, evidence suggests that both capacity and financial incentives towards productivity can play an important role. On the demand side, inducing a raising of clinical thresholds may reduce waiting times but may also provoke tension between clinicians and policy makers. Preliminary evidence also suggests that an increase in private health insurance coverage may reduce waiting times.

Keywords: Waiting times; Elective surgery; International comparisons; Policy

1. Introduction

Waiting times for publicly-funded elective surgery are a major health policy concern in approximately half of all OECD countries. Mean waiting times for elective surgical procedures are above three months in several countries and maximum waiting times can stretch into years. They generate dissatisfaction for the patients and among the general public. Is there a solution?

This paper provides a comparative analysis of policies across 12 OECD countries (Australia, Canada, Denmark, Finland, Ireland, Italy, The Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom),[1] all of which have reported waiting-time problems for public patients. It is argued that, in principle, waiting times can be reduced through supply-side policies, if the volume of publicly-funded surgery is not considered adequate by policy makers, or through demand-side policies, if the volume of publicly-funded surgery is considered to be adequate. In the follow-

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[1] For Spain the analysis mainly refers to Insalud, while for the United Kingdom it refers to England.

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ing paper, Section 2 contains a framework to describe the waiting-time phenomenon. Section 3 is devoted to a review of policies, which have been adopted to tackle waiting times. Section 4 contains concluding remarks.

2. The waiting-time phenomenon

Waiting times for publicly-funded elective surgery are a major health policy concern in many OECD countries. Public opinion surveys suggest that waiting is very unpopular ([1] for United Kingdom and [2] for Spain). For the patients, the costs of delay can include deterioration in health status, prolongation of suffering, loss of utility and uncertainty. Waiting lists generally tend to be found in countries, which combine public health insurance, with zero or low patient cost sharing, and constraints on surgical capacity. These prevent supply from matching demand. Non-price rationing, in the form of waiting times for elective surgery, takes over from price rationing as a means of equilibrating demand and supply. Fig. 1a depicts the way in which patients flow through a typical health care system. Patients arrive for assessment by a surgeon as emergencies or after having been referred by a GP. After assessment, patients who do not meet whatever thresholds are set for adding them to the waiting list, are referred back to the GP (or to another specialist). Others will be treated as emergencies or as urgent patients and be offered surgery without waiting. Still others, for whom surgery can be scheduled, may be asked to wait for elective surgery and be given a future date for treatment or put on a public waiting list. Some of this last group may choose private surgery to 'jump the queue', provided they can pay for it or are privately insured.

The determinants of waiting times and lists can be divided into those which affect the demand for treatment – or inflows to the waiting list – and those which affect the supply – or outflows (Fig. 1b). The *demand* for surgery is determined by factors which include: the health status of the population; the state of medical technology, which determines the range of conditions which are treatable; the thresholds for treatment set by surgeons; patient's expectations; various financial incentives, such as the extent of cost sharing by public patients, the proportion of the population with private health insurance (PHI); and the price of private surgery. The *supply* of surgery depends on both public and private capacity and the productivity with which capacity is used. Productivity depends, among other things, on the way in which surgeons and hospitals are paid. For example, activity-based funding (of the DRG type) is likely to encourage higher productivity, for example through a more intensive use of theatres or beds, compared to funding based on fixed budgets. There are also *feedback* effects from waiting times to quantities demanded and supplied of elective surgery (dotted arrows in Fig. 1b), because waiting times act rather like prices do, helping to equilibrate demand and supply. Other things being equal, higher waiting times may reduce demand by discouraging GPs from making referrals and by deterring surgeons from adding patients to lists [3–5], by encouraging patients to take out private health insurance [6] or to buy private surgery, out-of-pocket. At the same time, higher waiting times may increase supply by encouraging public authorities to allocate more money to public hospitals with longer queues [7–9]. Likewise, higher waiting times may be an indirect signal to private hospitals to expand activity. Both demand and supply will be subject to shifts through time because of factors such as changing technology and the ageing of the population.

Waiting times can be measured in different ways. We define "the waiting time of the patients *admitted* for treatment" as the time elapsed between the specialist placing the patient on the waiting list and the time of treatment as an inpatient or day care. We define the "waiting time of the patients *on the list*" as the time that patients have waited on the list at a census date. In general, the two measures will differ. On the one hand, the full length of waiting of any patients measured under the "waiting time of the patients admitted" always exceeds the partial length of any patient measured under the "waiting time of the patients on the list" (interruption bias). On the other hand, it is patients with longer than average full length of waiting who are more likely to be in progress when the "waiting time of the patients on the list" is measured (length bias). Also, the patients "on the waiting list" may not always end up in receiving the treatment. For example, they may move house, be admitted as emergency patients, decide to purchase private treatment or die. Hence, they may not be included among the