WHAT WORKS? WAITING TIME POLICIES IN THE HEALTH SECTOR

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Summary: Various policy tools have been used across OECD countries to reduce excessive waiting times in the last decade. The most common policy is some form of maximum waiting-time guarantee. Increasingly, such guarantees are backed with targets for providers and sanctions for non-compliance. The guarantees often go hand-in-hand with choice, competition and an increase in supply. These policies have been successful in reducing waiting times. Demand-side policies attempt to define more rigorous clinical thresholds. However, they have proved difficult to implement. A promising policy is to link waiting-time guarantees to different categories of clinical need, a form of prioritisation.

Keywords: Waiting times; Guarantees; Targets; Patients’ choice; OECD countries

Introduction

We review various policy tools that OECD countries have used to reduce excessive waiting times in the last decade. Compared with an earlier OECD study where supply-side policies predominated, the most common policy identified in the second OECD waiting time project is some form of maximum waiting-time guarantee, which often combines supply-side and demand-side measures. Increasingly, such guarantees are backed with targets for providers and sanctions for non-compliance. The guarantees often go hand-in-hand with choice, competition and an increase in supply. These policies have been successful in reducing waiting times. In contrast, most attempts to increase supply temporarily in order to decrease waiting times have met limited success. This suggests the need to work simultaneously on supply and demand-side policies; for example, by conditioning increases in supply on simultaneous reductions in waiting times (to limit subsequent increases in demand). Demand-side policies attempt to define more rigorous clinical thresholds for treatment. However, they have proved difficult to implement. A promising policy is to link waiting-time guarantees to different categories of clinical need, a form of waiting time prioritisation. This article outlines some of the key country evidence from our OECD study.

Maximum waiting-time guarantees, targets and sanctions: England and Finland

England and Finland have combined waiting-time guarantees with sanctions for failure to fulfil the guarantee. In England, maximum waiting-time guarantees were set at twelve months in 2002–03, and progressively ratcheded down to

* The content of this article draws heavily from Chapter 3 of the report.
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The use of waiting-time guarantees raises concerns over incorrect prioritisation, gaming or changes in referrals. For England, Propper et al. did not find evidence for such behavioural changes. However, Dimakou et al. found that the probability of patients being treated increases when the wait approaches the target, and falls when the wait is above the target, which may be consistent with incorrect prioritisation: giving priority to lower severity patients approaching the target and increasing waits for higher severity patients below the target.

Evidence from England indicates that guarantees with sanctions reduce waiting times. Waits of over six months have virtually disappeared. Targets with penalties were introduced during 2000–05, with strong political oversight from the Prime Ministerial Delivery Unit and the Health Care Commission. Senior health administrators risked losing their job if targets were not met. Compared to Scotland (where no penalties were introduced), Propper et al. found that in England the proportion of patients waiting over six months fell by 6–9 percentage points.

Finland also introduced a strong waiting time guarantee combined with targets as part of the Health Care Guarantee 2005, subsequently incorporated into the Finnish Health Care Act of 2010: primary care services are provided within three days; and patients are referred from primary care to an out-patient specialist within three weeks. For elective surgery, any evaluation should occur within three weeks; diagnostics within three months; and surgery within six months of assessment. The introduction of the legal guarantee resulted in the number of patients waiting over six months to decrease from 126 per 10,000 population in 2002 to 66 per 10,000 in 2005. The National Supervisory Agency (Valvira) supervised the implementation of the guarantee and penalised municipalities failing to comply. Valvira provided targets to municipalities for the number of patients waiting over six months, progressively lowered from 15 per 10,000 population in 2007 to 7.5 in 2009 and 5 in 2010. Almost all hospital districts met the targets, but Valvira had to issue 30 orders for improvement, including eight threats of fines.

For the past two decades, Portugal has tried to solve its waiting time problem with bursts of additional funding under four initiatives during 1995–2009. In all four cases, waiting times declined initially but subsequently increased. Portugal has found an innovative solution through a combination of guarantees coupled with a new integrated system to collect wait information from all public and private hospitals, known as Integrated Management System of the Waiting List for Surgery (SIGIC). One key feature of the SIGIC is the use of a treatment voucher to operationalise the guarantee. When patients on the list reach 75% of the maximum guaranteed time, a voucher is issued that allows them to seek treatment at any public or private provider. This creates incentives for public hospitals to treat within the guarantee. The national waiting list for surgery declined by 39% from 2005 to 2010, even though demand increased. The improvement is partly due to better management, the shift from a decentralised to centralised information technology (IT) system, and the use of the IT system to implement the guarantee, allowing patients to find other providers, thus introducing choice and competition.

**Activity-based funding and socially acceptable waiting times: the Netherlands**

A common policy to encourage providers to increase the volume of patients treated is to use activity-based funding (ABF) that pays a price for each additional patient treated. The change of hospital payment methods towards ABF and the removal of a hospital spending cap was the key policy that resolved long waits in the Netherlands. In 2000, the government considered introducing a maximum waiting time guarantee for hospital care, which was motivated by a court decision in 1999 that patients have an enforceable right to timely care. A formal guarantee was ultimately not introduced because of concerns about the cost of operationalising the policy. However, the national associations of hospitals and insurers agreed on a socially acceptable waiting time (known as “Trek norms”) of six weeks for day treatment (80% within four weeks), seven weeks for in-patient treatment (80% within five weeks), and
four weeks for hospital specialist diagnosis and medical assessment (80% within three weeks). In 2001, the fixed budget scheme was replaced by ABF. The government also abolished restrictions on medical specialist positions in hospitals. Hospital and specialist incentives were aligned, and production rapidly increased and waiting times decreased substantially. The Dutch combined a relatively soft guarantee linked to choice with competition linked to ABF. In 2011, mean waiting times for almost all surgical procedures were four weeks or less. There is an on-going discussion about re-introducing hospital budget caps as part of a policy to curb spending.

Prioritisation of patients on the waiting list: New Zealand

A demand-side policy to reduce waiting times involves introducing clinical thresholds below which patients are not entitled to publicly-funded surgery, thus decreasing the “inflow” to the list. New Zealand has been at the forefront of using demand-side policies, where a patient is entitled to elective surgery conditional on need and ability to benefit as assessed by the specialist. Patients are referred by their GP, and the specialist assessment determines whether the patient goes on the list. Patients are classified into: booked; certainty of treatment; and active care and review. Patients in the first and second groups are treated within six months. Patients in the third group have the least severity and do not enter the waiting list. They are referred back to their GP, who treats them and monitors their health status. If the condition deteriorates, these patients can change group.

This innovative scheme of demand management dates back to the 1990s, when the country developed clinical prioritisation assessment criteria (CPAC) tools to manage waiting lists. A distinction was made between the clinical threshold where patients benefitted from treatment and a higher “financial threshold” which the health system could afford. Many CPAC tools were multi-dimensional, integrating objective and subjective clinical criteria combined into a composite score. Integrated tools were also developed in some specialty areas (orthopaedics, ophthalmology and plastic surgery), where clinicians first ranked conditions against each other, with each condition being allocated a score from 1 to 100. At one point, CPAC tools for 29 specialities were listed on the Ministry of Health website. One critical implementation issue was whether to use national or locally developed tools. Even when national tools were used, there were still variations in scoring and clinical thresholds. There were also issues with developing valid and reliable tools for measuring patient need/severity and the benefit from surgery.

With these caveats, the focus on clinical prioritisation has resulted in the number of patients with a commitment to treatment (booked or given certainty) waiting more than six months to decline from around 7000 patients in 2002–06 to around 3000 patients in 2007–10.

Individualised maximum waiting time guarantee: Norway

Given the concern with incorrect prioritisation caused by maximum waiting-time guarantees, Norway has tried to condition the guarantees on the basis of need using criteria such as severity and effectiveness of treatment. This is essentially an “individualised” guarantee, where a maximum wait is determined by the patient’s condition, need and severity. It was introduced in 2002, with patients classified into three groups: emergency patients who should receive treatment with no further delay; elective patients entitled to an individual maximum waiting time; and less severe elective patients not entitled to a maximum wait. If the individual guarantee is not fulfilled, patients can be treated in another hospital or abroad. Unfortunately, evidence suggests that increased prioritisation did not take place.

Dedicated/additional funding has not proved successful

One policy commonly used by countries is some type of targeted-funded programme to reduce waiting times. Despite being the most common approach across OECD countries, it has invariably failed. These programmes are short-term bursts of funding that are insufficient to raise capacity significantly. Furthermore, it is not only funding, but the wider institutional setting that determines incentives to increase production. In general, short-term funding targeted at waiting lists and waiting times has proved unsuccessful. This may be because it fails to address the structural issues that determine waiting times, leads to a subsequent increase in demand, or is targeted at a specific waiting list. Although it should be possible to spend sufficiently to reduce and even eliminate waiting times, this would require massive investment, which is unlikely to be available in a time of fiscal constraint. One possible way forward is to fund higher supply conditional on reductions in waiting times (i.e. funding is not provided if the higher supply does not translate into lower waiting times) in order to control potential demand inflows.

Conclusions

Over the past decade, waiting-time guarantees have become the most common policy tool to tackle long waiting times, but are effective only if enforced. There are two approaches to enforcement. The first entails setting targets and holding providers to account for achieving them. The second allows patients to choose alternate providers, including in the private sector, if the wait exceeds a maximum time. In England and Finland, hospitals were penalised for exceeding targets. As a result, waiting times decreased. This method is, however, unpopular with health professionals and difficult to sustain long-term. Portugal, the Netherlands and Denmark successfully introduced choice and competition, and this is the direction recently taken by England. The Portuguese model has been effective in decreasing waiting times. The model entails a unified information system containing data on waiting times for public and private providers, and vouchers that allow free choice issued to patients when 75% of the waiting time guarantee is reached. The Netherlands successfully eliminated waiting times by a combination of ABF, lifting a cap on hospital spending, allowing choice and competition, and introducing waiting time norms. However, these policies tend to be expensive and, given the current economic environment, may not be feasible in all countries.
A complementary approach to reducing waiting times is to implement demand-side policies by introducing tools to improve clinical prioritisation. They have been used in New Zealand, with some success. Implementation can be difficult, as it is necessary to set a clinical threshold in a valid and reliable manner. In Norway, clinical prioritisation is linked to waiting-time guarantees, with guarantees varying according to need. This appears to be a promising approach, but requires better tools for clinical prioritisation that reliably measure clinical need and the benefit of the elective procedures.

References


