



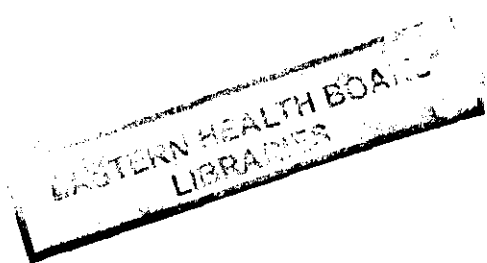
HOUSES OF THE OIREACHTAS

**Joint Committee
on
Health and Children**

**A COMPARATIVE ANALYSIS OF WAITING LISTS
FOR ACUTE HOSPITAL TREATMENT IN EU
COUNTRIES**

(Rapporteur: Liz McManus T.D.)

January 2001



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Foreword

The Joint Committee on Health and Children was established in November 1997. The issue of hospital waiting lists was an item for consideration in Committee's Work Programme for 2000.

At it's meeting on 17 February 2000, the Joint Committee appointed Liz McManus T.D. as a Rapporteur carry out a comparative analysis of waiting lists for acute hospital treatment in EU countries. The draft report was considered by the Joint Committee at it's meeting on 24 January 2001. The report, as amended, was agreed.

The Joint Committee is grateful to Deputy Liz McManus for her work as Rapporteur in researching and drafting this report.



Batt O'Keeffe T.D.
Chairman

24 January 2001

WAITING LISTS

A comparative overview

Only 24% of the Irish population expressed itself satisfied with our health services in a survey published last month by Eurostat, the statistical office of the European Commission in Luxembourg.¹ That compares to 70% in the Netherlands, 71% in Austria, 78% in Finland.

Waiting lists are clearly a major reason behind this low satisfaction rating.

The Eurostat data also records the highest death rate for males in the EU from both respiratory and circulatory diseases among Irish men. Among females, Irish women have the highest rate of deaths from respiratory diseases and the second highest for all cancers.

It is difficult to draw precise correlations between long waiting times and high death rates from cancer and respiratory and circulatory diseases. We are forced to conclude, nonetheless, that the link is more than purely coincidental.

A look at some facts

31,851 people are currently waiting for hospital treatment in this country. Many are debilitated by unnecessarily prolonged illnesses. Some die before they have the treatment.

This 31,851, however, indicates only part of the problem. Only those who have already seen a consultant and who have been diagnosed as needing hospital treatment are counted on waiting lists. In marked contrast to the practice in the UK and Northern Ireland, public patients here must also undergo a pre-list wait where they are undocumented for a period of three months as they wait to be added to the official list. This is often subsequent to an initial long wait to see the consultant.

¹ Key data on health, Eurostat, September 2000

of France and Germany where, apart from organ transplantation, waiting lists as we know them do not exist.

So, all countries are not in the same boat?

Let's look at the example of France

Recently assessed as being the best healthcare system in the world by the World Health Organisation, France does not have the problem of waiting lists. This is not to say there is no waiting period. Rather, under a "booking" system (similar to the system introduced in New Zealand in 1996), all patients are immediately given a date at which surgery will be carried out, thus reducing uncertainty and stress for the patient and family.

The French system copes with emergency surgery cases by running bed occupancy rates at around 75% so that the system runs, normally, under full capacity. Thus it can manage periods of peak demand without disrupting the booking system. In addition, the expansion of day care surgery has also helped in avoiding the problem.

To make some comparisons with Ireland: among French males, the death rate from circulatory diseases is 54% of that affecting Irish men (255 per 100,000 opposed to 465 per 100,000 in Ireland). Among French females, it is 52% of the rate affecting their counterparts in Ireland (146 per 100,000 and 279 per 100,000 respectively). Comparative death rates for men and women from respiratory diseases run at 46% and 32% of Irish death rates. In other words, France suffers less than half the rate of death for men and less than one third for women from respiratory diseases than we do in this country.

Close to 99.9% of the French population has medical cover through social security payments. Insurance is mandatory², whether employed, unemployed or self-employed and resources are not divided between the kind of two-tier system of health care we have in Ireland.

² 90% have cover through state medical insurance programme; remainder through other welfare bodies.

(iii) Ireland

In December 1996, just under 26,000 people in Ireland were on waiting lists. 74% of those waiting for cardiac surgery waited more than 12 months, as did 64% of those waiting for vascular surgery, 45% waiting for orthopaedics and 58% waiting for plastic surgery (see *Report of the review group on the waiting list initiative*, p.5). This was despite the additional £12 million invested under the Waiting List Initiative in 1996.

Target specialities in Ireland

If we look at what's happened in Ireland since the HOPE report was written, with the implementation of target specialities for waiting time reduction in certain key areas, the stagnation within the system is even more apparent.

Table 1.0 below indicates significant increases since 1996 in the percentage of people on waiting lists who are forced to wait in excess of one year for each of the target specialities outlined—except for cardiac surgery where the situation has changed little in the four intervening years. This increases have persisted notwithstanding the increased funding and reform measures implemented since that date.

SPECIALITY	DECEMBER 1996	DECEMBER 1999	JUNE 2000
Cardiac surgery	74%	73.25%	74.12%
Vascular surgery	64%	66.26%	70.77%
Plastic surgery	58%	58.95%	65.64%
Orthopaedics	45%	58.70%	50.25%
Opthamology	30%	39.09%	36.36%
Gynaecology	20%	31.09%	34.82%
Urology	37%	48.89%	52.67%
ENT	40%	57.70%	62.53%
Surgery (general)	27%	34.19%	33.44%

Table 1.0
percentages of total number on waiting lists waiting 12 months and above

If it was simply a matter of extra cash and better management, much greater inroads would by now have been made on the numbers waiting.

What do these figures mean in real terms?

The attached report, *Waiting lists for healthcare in developed countries—Initiatives for long term management*, notes that “targeted funding such as this is a short term measure. Such initiatives will not address the underlying cause of the waiting list growth” (p.33).

The most recent figures available show a drop of one sixth, from 36,855 in December 1999 to 31,851 last month, achieved with the enormous investment of £34 million this year and concurrent list audit measures. Going on previous years, this rate of throughput will only be sustained if the same level of investment is sustained.

If we look at the history of funding under the Waiting List Initiative since 1993, the temporary nature of improvements effected with targeted funding is borne out—especially given increased waiting times and the increase in total numbers waiting by over one-fifth since December 1993.

In March 1993, waiting lists stood at 39,423. £20 million additional moneys were invested under the Initiative in 1993 and by December of that year, the numbers had fallen to 25,373. By December of the following year, with a further investment of £10 million, the lists numbered 23,772, a proportionately much lower decrease.

The net effect of the Initiative appears to have plateaued by 1995 when, despite another £8 million specifically targeted at waiting lists, they had actually risen to 27,752 by December. It would seem that problems of capacity also set in.

As noted in the *Report of the review group on the waiting list initiative* (p.i, *Executive summary*, Appendix 3), “some hospitals have reached full capacity with existing resources in relation to elective work”—whereby hospitals are simply physically incapable of increasing throughput even with the additional resources offered through incentive payments.

In the UK, 75% of waiting list cases are concentrated among the five specialities of general surgery, orthopaedics, ear, nose and throat, gynaecology and ophthalmology. While considerable numbers of people wait for treatment under the NHS for unacceptably long periods of time, waiting lists also show significant local variations in the length of lists and waiting times.

Although only 10% of Britons access healthcare via the private sector⁵ (compared to 45% in Ireland), private medicine in Britain is also used as an avenue to skip queues in the public system—particularly at times when the public system is least able to cope with demands for its services.

As already indicated, waiting lists in New Zealand have been countered with the introduction of a booking system in 1996 for surgical procedures—preceded by investment of NZ\$130m to clear surgical waiting lists. At the same time, priority criteria have been developed to encourage treatment of most needy patients first. Resulting in greater efficiency and more productive use of resources, this has also had the added benefit of encouraging greater integration between general practice and the acute hospital system as patients with less serious conditions are treated locally by GPs.

Why are Irish reforms not working in the same way?

Too often in our society, decisions on healthcare are made in the interests of the most powerful. Nowhere is this more evident than the disproportionate level of care *paid for* and *provided by* the state to the private patient.

A recent report by the Economic and Social Research Institute, *Private Practice in Irish Public Hospitals*, revealed that private patients in public hospitals have half their costs covered by the taxpayer; that their health insurance covers just 50% of the actual costs incurred. Although private patients only account for one-fifth of all in-patient stays in acute public hospitals, one quarter of the hospitals' total expenditure on in-patient care is spent on them. Private patients are also subsidised by the state through tax relief on health insurance payments.

⁵ Fallen recently from 11% due to NHS reforms

Private hospitals piggyback on cash-strapped state-funded institutions as they rely hugely on consultants from the public sector. Financial incentives available to consultants in the private sphere, coupled with the lack of monitoring of work carried out under public contract, leaves open the *potential* for disproportionate time to be spent with the lucrative private market, further shifting the balance against the public patient.

The government review group which examined the problem of waiting lists two years ago (and which included five consultants among its 12 members) commented: "some hospitals or consultants may find it attractive to maintain a public waiting list because a proportion of those waiting may opt to be treated privately".

In 1989, the Commission on Health Funding said that some consultants did not fulfil their responsibilities to public patients because they could make so much more money in the private sector. The Commission recommended monitoring of consultants' obligations to the public system. The Department of Health are still attempting to reach agreement with consultants' representatives on a monitoring procedure.

Shortage of consultants

The negative effect of consultants dividing their attentions between the public and private sphere is compounded by the serious shortage in their number employed throughout the system. Nationally, we have more than twice the number of Non-Consultant-Hospital-Doctors (doctors in training, often young and inexperienced) as consultants, a fact which has serious adverse consequences for the health service, not least of which are waiting lists.

NCHDs actually keep many of our hospitals going. Supposedly in training, they regularly carry out unsupervised work tending to public patients on behalf of absent consultants. Inappropriate admissions via A&E by the less experienced NCHD often means that both treatment and discharge are delayed as NCHDs are understandably reluctant to take decisions necessary to progress patients through the system. Therefore, through no fault of his own, the public patient inside the system blocks admission for those still waiting

acceptance that public patients should wait long periods for care while private patients have fast-track access.

3. In the short term, greater investment, centralised control and management and prioritising and auditing waiting lists will help reduce the numbers still waiting for treatment. In the longer term, however, it is only by systematic, planned and gradual reform of our health system itself that we will ensure appropriate and timely access to care for all patients.

REPORT

Waiting Lists for Healthcare in Developed Countries – Initiatives for Long Term Management

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October 3, 2000

1. Introduction

Most, if not all, people when asked would undoubtedly say that waiting times for surgery and other medical procedures and investigations should be as short as feasibly possible. Yet waiting lists in recent times have become one of the focal points of the growing dissatisfaction with the Irish public healthcare system. To a degree waiting lists are a common feature of many modern public healthcare systems throughout the developed world, though differences do exist in the incidence of waiting lists within a system as well as in the relative size of the waiting list and length of waiting time. Ultimately waiting lists result from a mis-match between demand and immediate available supply and have been found to be a particular characteristic of publicly funded healthcare systems in which patients do not pay directly at the point of service. Given the nature of the commodity healthcare and assuming that the demand for medical procedures is related to clinical need, as determined by the physician, most initiatives implemented to address the problems of waiting lists in other developed countries have concentrated on the management of the supply side. Given the continued growth expected in the demand for healthcare it is clear that some of public healthcare rationing is unavoidable in the presence of limited available resources being available. This rationing should be carried out in an explicit, informed, efficient and equitable basis.

Waiting lists in themselves are not necessarily a bad thing. Indeed having waiting lists can, to a degree, help control costs in a publicly funded system. Certainly short waiting lists can improve efficiency by eliminating periods of inactivity associated with over-capacity. In addition a period of waiting can afford the patient time to reach a more considered decision regarding an interventions, particularly if there is a degree of risk and choice involved. However persistent long waiting lists and associated long waiting times for essential services and procedures go far beyond this and their existence questions a system's ability to deliver quality care. It is the time and nature of the waiting that is at issue – unreasonable waiting times are what we should be focusing on.

effects of trends in demographics and healthcare expenditure on public healthcare systems (Section 3) before concentrating on the various policy initiatives which may be taken to address this problem based on the experience of policy implemented to date in other developed countries (Section 4).

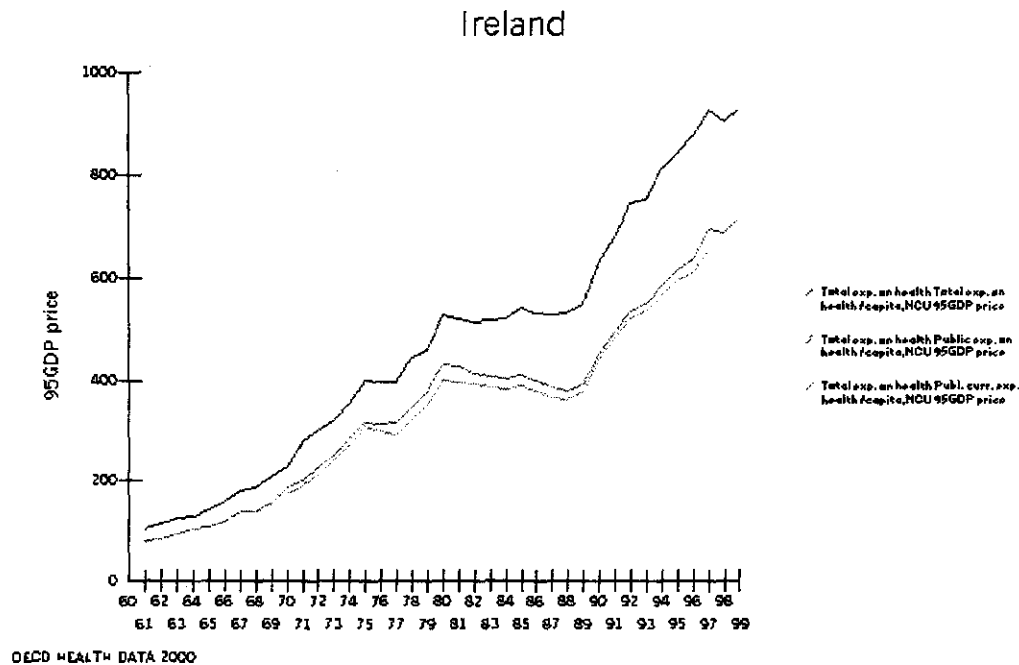
It is important to note that waiting lists and waiting times, as they have been experienced in Ireland, while worthy of immediate attention are just as symptom of an underlying malaise. The issue of waiting is closely related to that of priority setting – we have already described how waiting lists can be viewed as an implicit form of healthcare rationing. It is widely accepted in the international literature that given the growing demand on health care resources some form of rationing is inevitable in the healthcare sector. While the question of how we prioritise healthcare is not directly at issue here it is certain that any solution of the waiting list/time problem extant within the Irish healthcare system would give a clear signal of prioritisation decisions regarding delivery of public healthcare. Prioritisation will have to be explicitly made not only across the lists for different procedures but also within individual lists. The first level of prioritisation should naturally reflect society's values. To the extent that this is possible the agenda would be better set at a political level in consultation with healthcare managers and clinical professionals rather than leaving it up to ad hoc decisions made at local levels. Prioritisation within the various lists is at the core of the equitable and efficient management of waiting lists and as such will be discussed in section 4.

2. Experiences of waiting lists in other developed countries

2.1 General determinants of public waiting lists

As mentioned in the introduction, waiting lists for healthcare and the rationing implicit in those waiting lists result from a basic imbalance between supply and demand. In the case of organ transplants it is a case of commodity scarcity and typically people on the list are evaluated on the basis of medical condition weighted by time on the waiting list – this is a simple case of material scarcity. Far more serious are waiting lists for elective procedures resulting from fiscal scarcity and subsequent insufficient resource allocations in the face of such constraints. Clearly this is a form of rationing as it results from a lack

We must ask then why have these waiting lists come about in the Irish context, to a certain degree their growth was insidious but expected given the cuts experienced in the 1980's. During this the country was undergoing a period of fiscal rectitude. We can see from figure 1 below there were serious cuts in public healthcare expenditure from the beginning of the 1980's through to 1988. At the beginning of 1980 Irish healthcare expenditure as a % of GDP was 8.7% at £1797 million (1995 prices) by 1989 it had dropped to 6.6% at £1295 million.



Throughout the 1990's we remained significantly below the OECD average and somewhat on a par with the United Kingdom, see Table 1. Clearly in a period in which the national finances are in such a state, cutbacks are inevitable and public healthcare as a high expenditure area is an obvious target.

This reduction in funding coupled with the obligation of healthcare managers to manage their resources within budgets and give priority to emergencies was the cause for the growth of many waiting lists. Faced with such priorities it is difficult for managers to reduce waiting lists as available system capacity is absorbed dealing first with priority cases while elective cases present at a higher rate than they are being routinely treated. Essentially the state we find our healthcare system in at the present time is a legacy from the cutbacks in the 1980's from which the healthcare system has failed to recover and which can only ultimately be addressed, given the current state of national health, through

policy side in addressing the issue of waiting lists as they occur in their healthcare system and have become a greater issue of public concern and urgency. Typically there has been a concentration on high profile areas such as coronary artery by-pass surgery. An extensive literature search was conducted using medline and over 80 articles relevant waiting lists were identified, all of which were published since 1990. Of these 80 articles 70 referred to surgical procedures with the majority (40) as expected concentrating on cardiac surgery waiting lists. Articles referring to waiting lists for transplant surgery were not considered. The spread of articles over countries was as follows; Canada - 14, New Zealand - 7, United Kingdom -10, Netherlands -3, Australia -2 and general articles not referring to any specific country - 4. Thus our analysis of the experiences and responses to public healthcare waiting lists is significantly curtailed. The absence of supporting literature for a country does not imply that there is no waiting in that particular system. It is more likely that the absence of information on European countries has more to do with waiting lists being seen as an internal issue and discussed and debated internally rather than in international journals. It is of no coincidence that four of the five countries identified are all English speaking and that therefore their internal journals are more widely available for our investigation. It is also not surprising to find nothing on this area in the literature from America. The American system heavily penalises those without insurance coverage or independent means of payment. The American public healthcare system is relatively small and generally does not engage in large-scale elective surgery. An individual can either afford the treatment or can not. It would appear that there is little objective comparable information on waiting time and waiting lists in Europe or anywhere else.

2.3 Waiting experience – Canada

During the 1990's Canada experienced significant structural changes to its healthcare system, with fiscal circumstances creating pressure on the system to do more with less. Their approach was to initiate widespread operational reorganisation largely focused on regionalisation and moving patients closer to home. This has resulted in growing concern within Canada about diminished access to care in certain regions which traditionally have not had good service coverage. In part this reorganisation has led to what has been

short term effect on reducing the level the waiting list but that within two years the lists were back to their per-intervention level due to increased referrals,(Frost C 1980). In recent years the UK approach has concentrated heavily on list audit and list management as the primary method of controlling waiting lists, (White A 1998). They have also implemented a small degree of prioritisation concentrating particularly on patients who are reaching a pre-set maximum wait threshold for certain conditions. These maximum wait programs have also been implemented to a degree in Sweden. This issue of waiting lists remain a current problem within the NHS.

2.5 Waiting experience – New Zealand

The issue of waiting lists in New Zealand has been in the public domain since before the 1990's. However as a part of the restructuring of their health system which began in 1992, with the stated aim of achieving greater levels of assessment and accountability in the publicly funded health system, they established a committee to advise the Minister of Health on the types and relative priorities of health services which should be provided by the public system. One of its first reports recommended, for surgical services, a complete move away from a system of waiting lists towards system of specific booking times based on formal prioritisation (White A 1998;Fraser G 1993). Priority would be given to patients with the greatest likely benefit. The principal goal of this undertaking was to achieve the maximum possible population health gain with the available funds. Since the publication of this report much work has been done in New Zealand on formalised priority setting for surgical procedures and New Zealand has been a fertile testing ground for such instruments. The net effect of these measures has had a dramatic impact on the nature of 'waiting' within the New Zealand system.

2.6 Waiting experience – France

Not all countries with large active public healthcare systems have experienced a waiting list 'crises' in recent years and as such they are more difficult to document. France however is a good example of a country, which for the most part, has not experienced significant waiting problems except in the area of organ transplantation.

thus giving the disadvantaged access to all care without charge – thus encouraging them to go through a physician rather than initially presenting at a hospital.

Essentially therefore France has no significant hospital waiting lists outside of transplantation. They operate a booking system in which patients are free to choose any physician. By systematically running the system under capacity they allow for fluctuations in demand and avoid the problem of backlogs developing which would disrupt the booking system. Clearly all this comes at a price. Since the 1960's France has been highest spenders on healthcare in Europe. They finance their public system largely through dedicated social security payments which accounted for 75% of total health expenditure and 93% of public health expenditure in 1996. These social security payments are supplemented by central funds. This level of direct expenditure on the healthcare system is certainly reflected in France's premier position in the WHO World Health Report (2000).

3. Implications of future trends in healthcare utilisation

The demand for healthcare in developed countries, including Ireland is expected to rise in coming years partly as a result of demographic shifts, specifically ageing populations which will result in a significant increase in chronic diseases of old age (Hurst J 2000). Simultaneously healthcare costs can be expected to rise due the labour intensive nature of healthcare and the normal experience that sector specific wages tend to rise in line with general wage trends. This cost increase will be further exacerbated by the continuous growth in high technology medicine, particularly where focused on quality/quantity of life extension of an ageing population. Such a combination of rising healthcare demand and costs will probably result in an increase in public expenditure on healthcare as a % of GDP, which given the falling tax base associated with an ageing population can not be expected to be matched by an increase of tax revenue.

It is within such an environment that our healthcare system will have to operate. Current practice of implementing various waiting list initiatives are sufficient to cut numbers on

recent times there has been an effort made to audit individual lists it is not certain that a continual audit process has been established. The management and continuous review of the various waiting lists should be implemented on a more central level.

4.2 Targeting Funds

Additional funds to tackle waiting lists must be targeted. A good example of this are various waiting list initiatives implemented by the Department of Health and Children in recent years. Such an approach ensures that the funds address the correct area. However it is generally accepted that targeted funding such as this is a short term measure. Such initiatives will not address the underlying cause of the waiting list growth. Conversely international experience has show that targeted funding can spark a wave a new entrants onto the list which can actually result in the list increasing in size despite the funds allocated(Lewis; Barer; Sanmartin; Sheps; Shortt, and McDonald 2000). This occurs if physicians start placing patients on the list who the originally would have held back and managed in another way, knowing that they would not receive the intervention given their relative health status and the previous length of the list. At most targeted funds alleviate the major crises points while new structures are put in place to address the fundamental underlying causes.

4.3 Making use of the private sector

There is some merit in targeting funding to have procedures carried out in the private sector if the main constraint in the public sector is one of short term lack of capacity and the excess capacity exists in the private sector. This was the scenario in Ireland which has led to public patients being operated on in private hospitals. However such an approach can have a detrimental effect under conditions where there remains excess capacity in the public sector and when the underlying problem is one of insufficient funding alone and the if physician involved works in both systems. Under such conditions giving greater access to private care can be associated with longer public sector queues(Kingma 1995). This is particularly true when one has a market shortfall of human resources in healthcare where any formalised expansion of the private sector would be likely to further drain an entire spectrum of staff away from the public sector.

attempting to place patients on the elective list in some uniformly recognised order of need.

The concentration in the media and the resulting political emphasis on the raw numbers on the waiting list and the length of time spent on the list erodes the physician's ability to treat according to urgency. One of the potential problems of earmarking funds to specifically reduce waiting lists is that the incentive is to reduce the numbers on the list by targeting a greater number of the less complex cases. That those cases left on the list may be more cost effective based on potential changes in patient health status is not considered. This is a weakness of targeting funds in a short term 'waiting list initiative' which a priority scoring system would also address.

4.5 Priority Scoring Systems

The central argument in implementing a scoring system is that of introducing transparency and thereby equity into the waiting list system. As well as being used to determine a person's position on a list they can also be used as a 'threshold' measure of being initially accepted onto a particular list. A scoring system for healthcare procedures is not comparable to one for public housing. A entire battery of ethical, technical and managerial issues arise. Should scoring system should be tailored to each list individually or should common criteria be applies across several clinical specialities? What weighting is given to the various clinical and social variables? Whose prioritisation criteria should be used? For the successful implementation of such a scoring system the active involvement of healthcare professional and managers would be essential. It would have to be stressed to healthcare professionals that such a prioritisation system is not seeking to diminish their professional liberty but rather free them from undue pressure to favour individual patients. In this manner they loose little of their clinical discretion as they are actively involved in establishing the individual's score.

The scoring mechanism would ideally be developed using a Delphi type technique where professional consensus has been achieved. It must be easily incorporated into routine clinical procedures and be replicable independent of the physician. The scoring system would provide a process which would be both fair and consistent across the various health

5. Summary

- Public healthcare systems require targeted funding to address underlying causes of waiting lists and reduce them in a sustainable manner
- Demand for healthcare is projected to grow significantly in the future. Mechanisms should be put in place at this stage to prepare for increased demand
- Private healthcare should not operate at the expense (financial and labour) of the public healthcare system
- More centralised control of waiting lists – control at a regional level rather at the individual consultant/hospital level
- List reviews should take place on a regular basis backed by sufficient information technology
- Explicit prioritisation and the general use of scoring systems should be used in the general management of lists

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Appendices

APPENDIX 1



Measures to Reduce Surgical Waiting Lists.

1. Introduction
2. Healthcare systems, arrangements & practice
3. The Initiatives
4. Outcomes
5. Ongoing Management of Waiting Lists
6. Outpatient Waiting List Management
7. Primary Care
8. Discussion
9. Conclusions And Recommendations
10. Literature review
11. Demographics

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Each country responded differently in designing initiatives to address these difficulties. Responses to the problem took place at national, regional, secondary and primary care levels. Because of the differing structures of healthcare systems in the participating countries, each level is not pertinent to the initiatives addressed in each country. At the same time however, in attempting to understand waiting lists and waiting times and the initiatives taken to address them, it is important that the ways in which each level impacts upon the other are taken into account.

The report begins with a short account of the socio-economic and demographic features of each country and of its healthcare system and concludes with a literature review of the topic.

Those who are covered by the General Medical Services scheme (GMS) are entitled to a full range of publicly funded health services without charge. Eligibility is determined according to income, but discretionary powers remain with the regional health authority according to the individual's circumstances.

The main entitlements are:

- General practitioner services
- In-patient hospital services in public wards
- Specialist services in out-patient clinics
- Prescribed drugs, medicines and medical and surgical appliances
- Dental, ophthalmic and aural services
- Maternity care and infant welfare services.

Those not covered by the GMS scheme may avail of in-patient hospital service in public wards and specialist service in out-patient clinics, subject to a small charge.

Contracting and accountability: The clinical independence of consultants working within the acute hospital system is protected by the contract under which they are employed. Within the contract, a consultant is defined as *'a registered medical practitioner in hospital practice who...undertakes full clinical responsibility for patients in his care, or that aspect of care on which he has been consulted, without supervision in professional matters by any other person'*. The contract recognises and expressly protects the right of the patient to the independent judgement of his personal consultant.

The extent of private healthcare: Details of private expenditure on healthcare are patchy. Of claims paid by the Voluntary Health Insurance Board (VHI) over 70% are to hospitals and over a quarter are in respect of consultant fees. Approximately one third of the population are covered by private health insurance. A range of schemes are provided, with an emphasis on covering the costs of in-patient hospital care. Health insurance premiums qualify for tax relief at the standard rate of tax, provided the insurance is with a company based in Ireland. Private insured health care has been financed almost exclusively through the Voluntary Health Insurance Board, a not-for-profit statutory organisation. In the past year, the VHI has been joined by BUPA (U.K) in the private health insurance market.

	% GNP/ GDP on healthcare	Acute hospital beds*	Primary care physicians*
Spain	7.6% GDP	3.6	0.83
Finland	8% GNP	2.9	0.5
Ireland	7.3% GDP	3.3	0.48

*per 1,000 population

validation process, 21.7% of patients were removed from the lists. However, as an unforeseen consequence of the validation process, the overall number of those waiting for surgery grew when all patients were taken into account. In order to prioritise those waiting for surgery, indications for operations were devised in collaboration with groups of medical experts from national specialty associations which regulated how priority setting between different groups of patients should be organised.

South Karelia: Validation of the waiting list was undertaken by the local waiting list group in South Karelia.

Ireland: In one large acute hospital whose initiative was studied for this report, a three-step priority rating was used in order to prioritise those waiting for surgery; however, criteria for deciding the priority rating was not standardised across the hospital.

Consultation and Goal-setting

Insalud: Criteria for surgical intervention were established by INSALUD working in collaboration with groups of medical experts from national specialty associations. Goals were set for the relevant hospitals by the Central Authorities, the first of which stated that: *"At the last day of the year, no patient will have had a waiting time in excess of one year and waiting time will be reduced from seven months to four months"*. These goals were part of a rolling process of goal-setting which still continues and evolves. In 1997 a pilot project was undertaken in two regions in seven certain designated procedures which stated a maximum guarantee where maximum guarantee times were stated as between six and eight months. These were set by national specialty associations. If the hospital cannot offer the treatment within the time limit, then the local authority must offer treatment at another hospital within the network or at a private facility. At hospital level, consultants and administrators met to review the goals and to decide how best they could be achieved locally. Hospitals were expected to re-allocate funds internally in order to reach waiting list targets.

South Karelia: The hospital consultant who spearheaded the initiative in the South Karelia Hospital presented the findings of his analysis of waiting times to the other consultants in the hospitals. Upon examining the data, the consultants concluded that a reduction in waiting lists was necessary and could be addressed. It was agreed that 75% of patients listed for surgery should receive treatment within three months.

Ireland: At national level in Ireland, consultation took place between the Department of Health and hospital managers during which targets were set for waiting list reduction. The goal was to eliminate waiting times in excess of one year for adults and six months for children. The specialties which were targeted by the initiative were: ophthalmology; orthopaedics; urology; ear, nose and throat surgery; gynaecology; vascular surgery; plastic surgery and general surgery. A separate initiative took place in respect of cardiac surgery. Furthermore, targets were set for the numbers of additional procedures by specialty which were to take place. As part of the initiative in the major acute hospital studied for this report, the hospital's senior management consulted widely with hospital consultants. In this particular hospital, it was agreed that two specialties, ophthalmology and urology would be targeted.

Regulations, incentives and penalties

In addition to other mechanisms, solutions to the problem of waiting lists included regulation, provision of incentives or imposition of penalties. In the INSALUD region (the only region employing penalties), a combination of all three were used:

Insalud: In the region, regulatory mechanisms designed by the regional health authority were employed to enforce compliance with the initiatives. Return of monthly waiting list information to Central Authorities became obligatory. Furthermore, additional finance totalling 19m. ECU in

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4. Outcomes

Insalud: The most successful aspects of the initiative are seen to be the standardisation of the waiting list information system and the obligatory minimum data set which was refined and implemented. The following aspects of the initiative are also seen as most successful:

- Waiting list definition
- Standardised registration systems
- Standardised criteria for placement of patients on waiting lists
- Prioritisation of list and selection of patients from list
- Waiting list review
- Provision of incentive payments for day cases

Outcomes of the initiative in INSALUD region can be seen in the following table:

	No. on list	Waiting time	Average wait (days)
1.6.96	168265	>1 yr.: 21525	217
31.12.97	148224	> 9 months: 826	98

In addition to a reduction in waiting lists and waiting times, activity also increased as is shown in the following table:

Surgery	1994	1995	1996	1997
Impatient	31,9640	286,705	336,981	339,134
Day	33,332	36,676	51,996	72,834
Minor	210,990	189,541	200,202	196,057
Total	563,962	512,922	589,179	608,025

South Karelia: The initiative increased surgical activity in the hospital. Orthopaedic and urological waiting list/time have changed greatly. Reduction in waiting times is shown as an Appendix to this document and in the following Table:

Ireland: The cost of the additional procedures which took place as a result of the initiative is as follows:

1993: 25m. ECU for financing 18,768 additional procedures

1994: 12.5m. ECU for financing 16,669 additional procedures

1995: 10m. ECU for financing 12,861 additional in-patient procedures and 12,078 additional outpatient procedures.

1996: 15m. ECU for financing 13,170 additional procedures.

During 1995, the targets set for additional inpatient and outpatient procedures were exceeded by 2,467 and 6,768 respectively. During 1997, 10m. ECU was made available for the waiting list initiative of which 1.25m. ECU was dedicated to the cardiac surgery waiting list. In 1998, 11.5 ECU will be made available and hospital managers and Chief Executive Officers of health boards will be held accountable to ensure that targets are met. Outcome data is not yet available for 1997. The Department of Health is commissioning an independent study of the waiting list initiative to date.

Quality and Customer satisfaction

Insalud is currently evaluating the impact of the initiative on technical and clinical quality. Changes in some quality indicators since the initiative are being studied (re-admission rates, morbidity and mortality rates). Furthermore, the impact on indicators for surgery and clinical practice in the most common procedures is also being studied. This will include: evaluation of awareness and knowledge of the guidelines, changes in rates of indicators for surgery and variation in demand. In South Karelia, no changes in technical or clinical quality were noticed during the initiative.

Waiting lists and waiting times had been a major source of complaint to Spain's *Defensor del Pueblo* (Ombudsman). During 1997, a significant decrease has been noted in the Ombudsman's annual report. In South Karelia, customer feedback is obtained annually by questionnaires and no change was noticed during the waiting list initiative.

Ireland

As part of the initiative, activity levels were monitored by the Department of Health to ensure that targets were being achieved. Data was returned to the Department on a quarterly basis by specialty which showed baseline and additional activity.

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7. Primary Care

Insalud

Co-ordination between primary and secondary care is recognised as vital and therefore both are involved in a Health Care Commission which has been created in each area. The following are being developed by the Commission:

- Referral systems between general practitioners and specialists
- Information dissemination between primary and secondary care in order to make waiting list data more accessible
- Analysis of general practitioners' referring behaviour

In order to control referral rates proposed guidelines for referral between general practitioners and specialists are being devised by national medical specialty associations and scientific societies. Evaluation of the implementation of the guidelines is planned. A maximum referral rate from primary care to secondary care has been established in 1998 after consultation between managers of primary care physicians and hospital managers.

South Karelia

As part of the overall initiative, a working group of representatives from primary and secondary care established goals for reduction in waiting times for primary care appointments. For primary care physicians working within a capitation system, it was agreed that a patient should see the general practitioner within three working days and that more urgent cases should be seen on the same day. At local level in South Karelia the working group agreed that these targets were desirable for all primary care physicians. These targets were reached. With regard to the hospital waiting list initiative, primary care professionals were motivated to co-operate since it is through them that hospitals are funded. An example of increased co-operation was the development of a new strategy for urology patients in primary care.

Ireland

A number of hospitals held meetings with their local general practitioners. It was noted that the areas of concerns of general practitioners were sometimes different to those targeted by the waiting list initiative. In the voluntary hospital cited in this report, general practitioners identified long waiting times for rheumatology and dermatology outpatient appointments as areas which impinged greatly on the quality of life of patients and their families. In order to address this, an "early consult" rheumatology clinic was established and a similar initiative is planned for dermatology. Fast-track referral criteria have been agreed and standard referral forms have been developed for use by general practitioners. Up to 80% of patients have been referred back to their general practitioner after one visit. Steps have also been taken to inform local general practitioners of waiting times, both by specialty and by consultant. Feedback is provided to the hospital by general practitioners at Hospital Liaison Committee meetings.

in the area of cancer treatment. However it must be recognised that priority setting within specialties does not help in resource allocation between specialties. We recommend that a public debate is initiated encompassing health care professionals and consumers to educate the population about waiting lists and clinical practice. Such a debate would help to raise awareness of the finite nature of health care resources, the need for rationing and help set national priorities for the allocation of available resources.

In the Finnish example quoted in this report no further prioritisation is considered necessary as targets are being achieved. This may not apply in the rest of Finland as the initiative under study is the most successful of the three Finnish initiatives.

Clinicians often make substantially different management decisions for similar clinical situations. This variation in practice often occurs in geographically close communities and is not consistently explained by differences in patient characteristics or preferences. Variation in management often includes practices that are inconsistent with good evidence about optimal care²¹. Evidence-based medicine is the conscientious and judicious use of current best evidence from clinical care research in the management of individual patients²². It is an emerging clinical discipline that brings the best evidence from clinical and health care research to the bedside, surgery or clinic and to the community. The performance of systematic reviews of health care has become the focus of an international group of clinicians, methodologists and consumers called the Cochrane Collaboration. These reviews provide evidence on the efficacy of preventive, therapeutic and rehabilitative regimes.

Three steps are crucial to the timely introduction of evidence into clinical decisions: getting the evidence straight, developing clinical policy from evidence and applying the policy at the right place and time. We recommend that attention to these steps be incorporated into the management of waiting lists.

This includes:

- Training and continuing medical education in critical appraisal of research literature
- Disseminating and providing access (paper and electronic) to systematic summaries of evidence about health care interventions
- Clinical policy development involving 'front-line' local practitioners with responsive local systems; the policy must achieve a balance between the evidence from research and the circumstances in which the evidence must be applied
- Recognising and overcoming barriers to applying evidence in practice.

In summary then, we believe we should move towards a position where practice insofar as possible is evidence-based. In the short term in the absence of evidence being available, we should aim for universally agreed best practice and to prioritise within that framework.

Data issues

There are difficulties in interpreting trends in waiting list statistics. Definition difficulties, absence of a generally agreed urgency rating system and lack of a systematic method of collecting information about outpatient waiting time all have been identified as contributing factors^{12,15}. The lack of standardisation makes it almost impossible to evaluate the impact of waiting list initiatives as changes in the numbers on the list may be due to changes in data collection rather than an outcome of the intervention. In Spain considerable effort was put into standardising entry to the list and improving the data collected; as in other countries, many anomalies were discovered. In both Spain and Ireland it is accepted that a significant proportion of those on the waiting list at the beginning of the waiting list initiative no longer wished to avail of surgery. In

outpatient waiting time reduction programme in 1997. We recommend that outpatient waiting times are monitored routinely as part of waiting list initiatives. Key points from the patient's perspective are the length of time from referral until seen in an outpatient clinic and length of time from referral until definitive treatment. These should be included in the waiting list initiative minimum data set.

Once the focus shifts from inpatient to outpatient care, the importance of the primary care system becomes more apparent. In Ireland, the Health Strategy stresses that care should be given at the lowest most appropriate level. In Finland explicit targets were set for waiting times to see a general practitioner. Finland is unique in that the hospital is funded from the primary care budget of the district in which it is situated. In all three countries, to varying extents, efforts have been made to involve general practitioners, to devolve care to general practitioners where appropriate, and to develop shared management protocols for common conditions. In Finland, general practitioners work in the Accident and Emergency department at weekends and in the evenings; patients are directed to the most appropriate doctor within the Accident and Emergency department. Deployment of general practitioners in an Accident and Emergency department in Ireland resulted in cost savings²³; this pilot project is now being extended to other Accident and Emergency departments.

We recommend that general practitioners be involved at national level in the process of national priority-setting referred to earlier. We further recommend that general practitioners at local level be involved in hospital waiting list initiatives.

A senior manager in the Irish health services drew our attention to the interdependence of waiting list initiatives and Accident & Emergency services. This was in the context of the pressure experienced in Irish hospitals during winter months when a rise in the number of emergency admissions leads to cancellation of elective admissions which may impact on waiting lists. If, on the other hand, efforts to reduce waiting lists are vigorously pursued, emergency patients may have to wait a number of hours within the Accident and Emergency department for admission. The importance of having adequate rehabilitation and extended care facilities to facilitate discharge of patients who no longer need acute hospital care was stressed. These observations highlight the complexity of health care provision in developed countries and the potential for unintended consequences when initiatives take place in one part of the system. We recommend that changes in all parts of the healthcare system are monitored when waiting list initiatives are introduced.

Monitoring

Reference has already been made to the need to strengthen and standardise waiting list information systems. The importance of monitoring all components of the health care system and not just in-patient data has also been stressed. When goals are expressed in terms of numbers or time on the waiting list, these are obvious indicators to use in monitoring progress. We feel it is important to monitor more widely than this.

Increased use of day surgery was a feature in Spain, Ireland and Finland. Five-day wards are also utilised in tackling waiting lists. However more complex procedures cannot be undertaken on a day-case or five-day basis. It is essential that patients requiring such procedures are not perversely left to wait indefinitely; waiting times for complex procedures must be routinely monitored. Similarly, waiting list initiatives may result in less priority being given to conditions not amenable to surgery or not requiring invasive procedural investigations. We recommend that data in relation to all specialties be monitored.

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9. Conclusions and Recommendations

Waiting list management should be seen as one component of achieving health gain for the population.

Within healthcare, choices must be made and prioritisation must take place within and between specialties.

Notwithstanding this, it is recognised that medicine must take place within an ethical framework and that we should specially take care of those who cannot provide for their own care.

Neither can healthcare take place in an economic vacuum and it is recognised that at some stage, choices must be made.

Careful account should be taken of value for money in every aspect of healthcare system.

Where possible, all intervention must be evidence based and where this is not possible, it should take place according to explicitly agreed best practice.

Waiting list management should be seen as part of a continuum of care which reaches from primary care through outpatient departments to hospital intervention and finally back again to primary care.

A minimum data set should be established which is standardised within and between countries.

There should be commonly agreed criteria for entry to waiting lists at national level.

Urgency criteria for intervention should be established.

Clear targets for waiting times should be set at national and regional level.

Information about waiting lists and waiting times should be made available and widely disseminated.

Terminology used should be defined and standardised both within and between countries.

There should be a clear responsibility designated for the management of waiting list. It is recognised that individuals with leadership qualities are those who will have the most success in management of hospitals and management of waiting lists.

Responsibility for management of waiting lists should be clearly designated and assigned to a level high enough to ensure compliance and objectivity.

Systems should be structured and managed in such a way as to ensure accountability at each level.

Systems should be examined to highlight the rewards and penalties which exist within them and in particular those which may be hidden or which may operate in a perverse way.

Further work should take place to develop these recommendations and to make them specific at European level.

The Dutch health ministry has also announced radical plans to tackle chronic problems of long hospital waiting times especially for eye, heart and orthopaedic surgery (5). The move was prompted by research showing that in the first half of 1996 up to 100 patients benefited from schemes offering faster treatment for non-medical reasons. Of the 450,000 Dutch patients awaiting specialist hospital treatment each year, 90% thought they had to wait too long.

A study was carried out between 1992 and 1995 into the total waiting time by public patients for selected surgical procedures in the greater Dublin area (6). Procedures studied were cataract removal, prostatectomy, transurethral resection, knee and hip replacement, herniorrhaphy, cholecystectomy and varicose vein operation. In paediatrics, grommet insertion and tonsillectomy/adenoidectomy were also examined.

Among the key findings were

Within any specialty, there was major variation between hospitals and between clinics within hospitals in waiting time to obtain an Outpatient Department (OPD) appointment, in the length of time one could spend within the OPD system and time on a waiting list for a surgical procedure

Length of waiting lists varied enormously between procedures: a median of 30.9 weeks on the waiting list for varicose vein operation compared to 4.6 weeks for a grommet insertion

Overall 71% of patients were satisfied with the length of time they were on a waiting list for a procedure

Those definitely dissatisfied with their time on the waiting list had waited on average over four times longer than those who were satisfied

Just over half of the patients considered their condition had disimproved while they were on the waiting list. This varied from 90% of those awaiting knee operations considering they had disimproved to 29% of those who were waiting herniorrhaphy

Satisfaction levels were much lower in those who considered their condition had disimproved.

That patients may be justified in their dissatisfaction with long waiting times is supported by a report of the potential dangers of long waiting times for a routine outpatient appointment at a urology clinic (7). Over a three year period, 55 patients with symptoms of bladder outflow obstruction were recruited for two clinical trials. These patients were recruited from the waiting lists of new patients and had been classified as having routine conditions by the consultant on the basis of the information in the referral letter. During the investigation of these patients, seven new cases of cancer of the prostate were diagnosed. A superficial cancer of the bladder was detected in one patient and a caecal cancer in another. The study highlighted the prevalence of associated disease in patients who were classed as having routine bladder outflow obstruction. At the time of the study, the average wait for a routine appointment at that outpatient clinic was eight months with a further wait of two years for a prostatectomy. The authors argue that since most of the prostatic cancers detected in the study had not metastasised to bone and were well or moderately well differentiated, these patients might have suffered if detection had been delayed. They conclude that a long wait for a patient with bladder outflow obstruction for a specialist opinion is

rationing at the micro level will increase tensions, conflict and instability.

Klein, Day and Redmayne illustrate the complex and multi-dimensional nature of the resource allocation process in service delivery (10). They stress the importance of non-medical decisions about priorities in the allocation of resources that may greatly affect the quality of care offered to patients and rarely feature in debates about rationing. They discuss factors influencing GP decisions to refer patients to hospital. They conclude that the rationing of access to specialist services by GPs tends to be an idiosyncratic process, affected but not determined by the availability of resources.

Idiosyncratic variation between consultants is also the norm, not only in the way they practice but in the way they manage access to services. Criteria used by consultants in managing the queuing system, in deciding priorities between patients on waiting lists, remain obscure. Where scales of urgency exist, it is unclear how these criteria are applied in practice: to what extent is there agreement between consultants in the way they define 'urgency', whether the concept is stable over time or changes with the availability of resources. In their interviews with purchasers, examples emerged of providers selecting out people they did not want to deal with e.g. speech therapists preferring middle-class children as clients to more difficult cases. In other words, resources were allocated according to the responsiveness or acceptability of the client.

Managing waiting lists

The long history and unchanging nature of the waiting list problem is illustrated by a detailed study of a waiting list for orthopaedic outpatient appointments in South Glamorgan Area Health Authority (11). The study was undertaken to identify factors that might lead to better management and reduction of the long waiting list. One third of patients on the list failed to attend when appointments were offered. A postal questionnaire to all those listed as waiting confirmed that many no longer sought specialist orthopaedic consultation. Another third of the patients reported that they had been treated previously for the same orthopaedic problem. Thus the study confirmed the widely held view that long outpatient waiting lists include both patients with conditions that have already cleared up and patients with long histories of chronic conditions. It is likely that many of these latter patients have problems which are not curable and where only palliative solutions are available.

The authors recommended periodic waiting list review with deletion from the list of those who no longer seek appointments. The proportion of non-attenders would then be smaller and more constant, allowing for better use of resources within the outpatient clinic. They also recommended that patients for routine review of refitting of appliances or supports should not be added to waiting lists as 'new' patients, but should be booked straight into clinics, even if at five-yearly intervals. Finally, they recommended that patients who have been through the system previously whose symptoms are not particularly amenable to treatment and who have been re-referred should be given a low priority by their referring doctors so that earlier appointments may be offered to truly 'new' patients with treatable or potentially serious conditions.

More recently, Pope, Roberts and Black examined a list of 1,283 patients waiting for general and orthopaedic surgery in an outer London borough (12). While the mean time spent waiting was 10 months, the distribution of waiting times was skewed, with most patients waiting a few months and a long tail representing those who wait for considerable periods, some over five years. In general surgery, varicose vein surgery and hernia repair accounted for nearly 60% of those waiting for more than a year. Of those waiting more than three years, varicose vein surgery and hernia repair accounted for 80% of the list. Amongst patients waiting for over a year for orthopaedic surgery a quarter were waiting for knee replacements and about 15% were waiting for hip replacements.

- Should these targets be reduced further?
- What implications do these targets have for setting priorities amongst patients?
- How should waiting times be measured?
- How long should people wait on these lists?
- Should there be shorter targets for some conditions, longer for others?
- Do clinicians have effective arrangements for deciding priorities within the lists?

The Health Committee examined the impact of waiting time targets in the context of low priority services. They found that access to 'non-essential' or 'low priority' services may be regulated in a number of ways.

1. A service may be excluded completely. The service may not be judged appropriate for NHS provision
2. Authorities may restrict availability by limiting the amount of money made available in their contracts: or, less likely, by specifying the maximum number of people to receive that service per year.

Evidence from district purchasers suggested that most had attempted to avoid imposing blanket exclusions on services. However, evidence from a majority of districts surveyed suggested that access to at least some 'low priority' services had been restricted. Exclusion or restriction policies differed markedly across the country both in terms of the services covered and the nature of the restrictions applied. The services most frequently subject to restriction included plastic surgery procedures undertaken for cosmetic purposes, tattoo removal, reversal of sterilisation and certain fertility treatments. While these involve asymptomatic non-threatening condition they can nevertheless raise very difficult questions for purchasers.

The Health Committee concluded that in terms of the impact on overall NHS resources, the absolute exclusion of services to date had been of marginal significance. The evidence suggested that purchasers tended to restrict access to services by limiting the availability of resources rather than exclude services completely. Many of the services excluded or restricted were those that previously had very low priority and hence very long waiting times. However, if purchasers continue to offer these 'low priority' services, all patients must be seen within the national target time of 18 months. It is partly in response to this pressure that some purchasers have taken an explicit decision to exclude local access to specific services. The Committee recommended the Department refine the operation of waiting time targets. They believed that some flexibility was necessary to avoid the potentially perverse distortion created by the need to treat all patients within the eighteen month time limit. This could be achieved by extending the practice of setting specific targets for treating specific conditions. They further recommended that the Department set out clearly the framework within which purchasers will be expected to define the local package of service, and set out the criteria by which their decision may be scrutinised, debated and if necessary challenged by individuals.

Hemingway and Jacobson questioned the assumptions that being on a waiting list is a measure of need and that the longer the wait the greater the need (3). These assumptions result in initiatives to reduce waiting lists tending to act as if it is the long wait itself that warrants treatment. They point out that increasingly, systematic reviews and techniques for identifying consensus have been used to set criteria of appropriateness for clinical procedures but that there has been little interest in using this work to tackle waiting lists. They suggested that where there is a waiting list, the intended procedure, the precise indication for that procedure and any co-morbidity must be assessed. These factors could be used to generate an appropriateness rating. They also suggested that commissioners agree with general practitioners and providers the criteria for appropriateness for entry to and clearance from a waiting list, that such an approach should be widely debated in

reforms, would merely shift delays rather than tackling the issue and that patients would end up waiting longer for outpatient consultations¹⁵. She drew attention to the long waits experienced by some British patients to be seen by a hospital doctor and the lack of a systematic method of collecting information about outpatient waiting. The most commonly used statistic is average waiting time per specialty, but that figure varies with local definitions and is so skewed by inter-consultant variation that it is virtually meaningless. She stated that reliable up to date information about outpatient waiting times is essential and that meaningful alternatives to measuring performance by averages are needed. Looking at centiles may give a better view of the situation.

This view is supported by the authors of the Dublin study referred to earlier⁶. They commented that comparison of the figures in their report with official data on waiting times (time on the waiting list) may be misleading. In general delay times, time in out-patients and waiting times, were positively skewed and median rather than mean values were presented. Because of the nature of this data, the median values tend to be less than the arithmetic mean usually quoted in official statistics. In an attempt to present the variability in waiting times (between clinics irrespective of hospitals, between clinics within hospitals and between hospitals) either the range or the quartiles were used. In addition, the report determined waiting time from placement on the waiting list to the actual procedure; the official statistics are based on how long patients, who were on the waiting list at a particular point in time, had waited up to that time.

Smith also drew attention to definition difficulties (16). There are three types of waiting list in Scotland

- True waiting list - number on the inpatient waiting list. In Scotland, patients on this list may be allocated a guarantee-exception code if their condition is of low medical priority e.g. tattoo removal, or patient referred to named consultants rather than to colleagues with lower workloads.
- Deferred waiting list - for patients who are under social or medical constraints which affect their ability to accept an admission date when offered and for those who fail to attend after being offered an admission date.
- Planned repeat waiting list - where care is planned over a series of admissions e.g. for chemotherapy.

As part of the monitoring process NHS trust and health authority league tables based on a snapshot of the number of patients on the inpatient waiting list are published at the end of each quarter. They show the number waiting in each specialty for specified time intervals and thus the number who have exceeded the guaranteed maximum waiting time for that specialty. The author aimed to determine whether the time spent on the inpatient waiting list gives a valid indication of how long NHS patients have to wait for treatment, and with reference to Scotland, how many patients are placed instead on the deferred waiting list or are exempted from the normal guarantees. The second aim was to determine the feasibility of measuring the total time that patients have to wait between the initial general practitioner referral for an outpatient appointment and admission for treatment, the post-referral time. The third aim was to assess the advantages of the post-referral waiting time over the currently used inpatient waiting time as a monitoring and decision making tool for general practitioner and health authority purchasers.

The study found that in the specialties investigated, approximately half of the average post-referral wait of 110 days was spent on the true inpatient waiting list, one third being spent on the outpatient waiting list and one sixth waiting between lists. The averages concealed wide variations in waiting times and overall there was little positive or negative correlation between the time spent on the outpatient and inpatient waiting lists. No patient on the true waiting lists had guarantee exceptions during the study period. Of 6417 patients on inpatient waiting lists in the three hospitals studied, 14.9% were on the deferred list.

Such a points scheme represents explicit rationing in an attempt to reconcile a limited supply of health care with demand. It can be seen as an attempt to make informal, covert rationing, which has occurred since the inception of the NHS, more formal, explicit and publicly accountable. The need to set priorities and in some way restrict access through eligibility criteria is increasingly widely accepted. Tudor Edwards argues that it is the nature of eligibility criteria, their philosophical basis and more pragmatically who is to set them that will lead to a diverse spectrum of opinion.

Before the NHS reforms, NHS waiting lists were the property of hospital based consultants who would decide who to treat and in what order. The creation of the internal market and separation of purchaser and provider raised questions as to the 'ownership' of waiting lists. Purchasers hold responsibility to meet the health care needs of their population, some of whom are on NHS waiting lists, while hospital based consultants face a responsibility to meet contracts on behalf of their provider unit, while trying to exercise their clinical freedom in managing their waiting lists. There is an issue as to whether consultants within a clinical specialty can reach agreement on the progression or spread of disease or condition, let alone on the pain suffered by a patient or his or her social circumstances. Inter-specialty consensus on the relative priority of patients treated in different clinical specialties is likely to be more difficult to achieve. A further criticism is that the points system does not explicitly link a patient's priority position on a waiting list to his or her expected health gains from treatment. There is no linkage between health gain and resources used.

The author goes on to describe how an efficient waiting list points scheme might work. An efficient waiting list policy, aiming to maximise health gain from available resources, might complement a general health care policy of giving priority to treatments and health care services that offer the greatest health care benefit per unit of resource, whether this be expressed in terms of £s spent or in terms of more physical units such as bed days. At an inter-specialty level, this would doubtless lead to the redistribution of resources e.g. bed capacity between clinical specialties. Patients would be drawn from the waiting list in order of their expected Quality Adjusted Life Year (QALY) gain per bed day from treatment. If this waiting list policy were carried out at the clinical specialty level, resources could be distributed between clinical departments so as to equate the total health gain per bed day of the marginal patient treated per time period in each clinical specialty. This would mean that patients would have the same opportunity of being treated, given their expected total health gain per bed day from treatment, regardless of the nature of their condition and clinical specialty from whom treatment was received. Such a policy is likely to leave some patients with minor conditions never being treated. A health gain per unit of resource maximisation based waiting list points scheme would fail to take into account factors such as time already waited, family and employment circumstances, and would only indirectly take account of factors related to quality of life, i.e. those incorporated into the health state descriptors used in QALY calculation.

The author applauds the architects of the Salisbury scheme for their recognition of the need to move the waiting list debate beyond waiting time targets. She proposes a research project to collect QALY data alongside the existing points scheme in order to identify how efficient the scheme is in terms of getting high QALY gain per unit of resource patients to the front of the queue. If the points scheme in its present form is leaving some high QALY gain per unit of resource patients languishing at the back of the queue, there is something to be learned about what might be an acceptable trade-off between health gain per unit of resource, and factors judged to determine deservingness of priority on a queue, such as dependence on other, loss of usual activity or time already waited.

As part of a sweeping overhaul of its economy and social structure, New Zealand implemented major reforms of its healthcare system in 1992, including a complete split between funding,

British on the one hand has decided not to define a list of core services available on the NHS and has left it up to purchasers to decide, providing them with information on the effectiveness of a range of treatments. On the other hand, it has developed several policies with direct bearing on rationing, such as curtailing free eye testing on the NHS, allowing adult dentistry to drift out of the NHS and requiring purchasers to meet specific waiting time and productivity targets for inpatient care regardless of the urgency or likely effectiveness of treatment in individual cases. The result, they conclude, has been haphazard access to care depending on where the patient lives and policies aimed at maximising effectiveness coupled with those likely to undermine it.

They contrast the situation to that in New Zealand, where there is also a split between purchasers and providers, where priority criteria were developed to encourage treatment of the most needy patients first. The authors consider that encouraging local providers to develop priority criteria for specific services as has been pioneered in Salisbury could be a next step in the NHS but urge a note of caution. There are important questions about which clinical and social factors to include and how best to weight them. Local criteria may conflict with national priorities. In addition, the New Zealand initiative helps to set priorities for demand within specified services but does not offer help about the appropriate mix of services, including whether some should be off the NHS menu. The approach may not be useful in deciding the level of funding for health care: in New Zealand the level of funding dictates the number of points at which a patient can expect treatment rather than the reverse. If the basic aim is to maximise health benefit from available funds, then the cost effectiveness of treatments, rather than just the effectiveness should be considered. Finally, the implication is that patients not achieving the required number of points are returned to their general practitioners for management. This may increase already high demands on general practice and ultimately result in higher costs of treatment. Despite these caveats, the authors conclude that adopting an approach such as the New Zealand model might encourage a shift of emphasis away from a counterproductive cycle of increasing hospital activity and the inflexible use of waiting times to rank demand towards increasing efficiency instead.

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Measures to Reduce Surgical Waiting Lists.

11. Demographics

Using the latest available figures, comparative data is given below for Spain, Finland and Ireland regarding each country's area, population, life expectancy, elderly and youth populations and those unemployed.

Spain

The population of Spain is 39.7m people in an area of 504,750 sq. km. Of those, 16.4% are 65 years or more. The birth rate is 9.8 per 1,000. Life expectancy is 77 for men and 78.5 for women. Spain has a crude mortality rate of 8.8 per 1,000 and the principal causes of death are accidents, cancer and vascular diseases. Using the European Union Community Household Panel Survey to assess poverty, 19% of households were found to be below the 50% poverty line.

Finland

In 1995, the population of Finland was 5.1 million, living in an area of 338,145 sq. km. The birth rate is 11.8 per 1,000. 14.5% of the population is aged 65 years and over. There is a crude mortality rate of 9.6 per 1,000 in Finland and the principal causes of death are: 20.3% of the deaths are due to cancer; 17.2% to ischaemic heart disease and 17.6% to other diseases of the circulatory system. Life expectancy is 72.8 years for men and 80.2 for women. Finland has been struggling with high unemployment which is decreasing and now stands at 15%. The Finnish variation between lowest and highest income groups is narrowest among the OECD countries and poverty figures are among the lowest. Using the European Union Community Household Panel Survey to assess poverty, 8.7% of households were found to be below the 50% poverty line.

Ireland

Just over 3.6m people live in the Republic of Ireland which has an area of 70,285 sq km. The birth rate is just under 14 per 1,000, a rate which reflects a fall which began only in recent years. The percentage of the population represented by those aged under 18 years is 32.5% as a result of very high birth rates in previous years. Of the total population, only 11.5% is aged 65 years or more although this figure is predicted to rise sharply within the next five years with a very significant rise in the upper age cohorts (75 years and over). In 1996, Ireland had a crude mortality rate of 7.3 per 1,000. Half of all deaths are due to diseases of the circulatory system, with a further quarter due to cancer. Eligibility for free medical care (or Medical Card) has been found to be the most reliable indicator of need and 40% of the population is eligible for this cover. Using the European Union Community Household Panel Survey to assess poverty in 1993, the proportion of persons below the 50% poverty line had increased when compared to 1987 figures. Of all households, 21% were found to be below the 50% poverty line in 1994. Households with an unemployed head were the most substantial group among the poor.

APPENDIX 2

Irish Medical Times

35 Years of Publication

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News & News Analysis

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Vol32No51 (Dec 19, 1998) : News & News Analysis

Health services in each of the EU member states

Austria

Number of Doctors	32 392
Number of Inhabitants per Doctor	247
Number of Hospital Beds	68 300 (Population: 8 million)
Hospital Beds per 1 000 inhabitants	8.5
Total health expenditure as a proportion of GDP	8.2%
Health Funding	Compulsory health insurance and state subsidies.
Health Insurance	Compulsory health insurance
Primary Care	Independent GPs compete for a fixed number of practices with a minute number in private practice. Group practice is outlawed
Manpower	In an effort to curb the high level of physician unemployment which currently stands at 8.9 per cent access to medical schools has been restricted. Women account for a very small fraction of professionally active manpower.

Belgium

Number of Doctors	36 000
Number of Inhabitants per Doctor	278
Number of Hospital Beds	59 800 (Population: 10.1 million)
Hospital Beds per 1 000 inhabitants	5.9
Total health expenditure as a proportion of GDP	7.9%
Health Funding	Main source is compulsory health insurance with significant state subsidy.
Health Insurance	Compulsory health insurance for all major risks
Primary Care	GPs Mostly in single-handed practices with payment on fee-per-service basis according to an agreed scale of fees
Manpower	The ratio of doctors to inhabitants has risen steadily over the past 30 years and there is now a surplus of doctors

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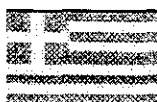
Number of Doctors	161 000
Number of Inhabitants per Doctor	350
Number of Hospital Beds	533 100 (Population: 58.1 million)
Hospital Beds per 1 000 inhabitants	9.2
Total health expenditure as a proportion of GDP	9.6%
Health Funding	Mostly funded from state sickness funds with some direct payments.
Health Insurance	National health insurance covers almost all persons
Primary Care	Mostly independent GPs but a small number practise from state run health centres. Patients are free to receive primary care from GPs or specialists so there is no clearly defined gatekeeper role for the GP.
Manpower	The number of practising doctors has increased by about 40% over the last fifteen years. However levels of supply remain average by European standards.

Germany



Number of Doctors	260 000
Number of Inhabitants per Doctor	312
Number of Hospital Beds	628 700 (Population: 81.6 million)
Hospital Beds per 1 000 inhabitants	7.7
Total health expenditure as a proportion of GDP	7.5%
Health Funding	Only 21 per cent funded from general taxation. Mainly funded from numerous insurance funds and a significant private sector.
Health Insurance	About 90 per cent of the population is covered by social security. About 12.5 per cent of population take out private health insurance.
Primary Care	Wide range of services provided in primary care setting by independent solo GPs. Primary care delivery is shared by GPs and specialists depending on the patient's choice and the prevailing condition.
Manpower	Due to an oversupply of doctors there is a significant level of medical unemployment (9.2%). Young doctors are encouraged to choose general practice over hospital specialties.

Greece



Number of Doctors	40 000
Number of Inhabitants per Doctor	303
Number of Hospital Beds	52 100 (Population: 10.5 million)
Hospital Beds per 1 000 inhabitants	5
Total health expenditure as a proportion of GDP	5.9%
Health Funding	Private sector accounts for around 25 per cent of total funding.
Health Insurance	Compulsory state insurance with a significant private sector with the rest coming from compulsory state insurance.
Primary Care	State-owned health centres co-exist with private GPs. Until recently GPs worked as civil servants only in rural areas. Now primary health care networks have been developed which consist of a central polyclinic and a number of satellite family doctors.
Manpower	High level of supply particularly noticeable at GP level. However regional distribution of doctors remains very uneven with a scarcity in rural areas.

Spain

Number of Doctors	159 000
Number of Inhabitants per Doctor	244
Number of Hospital Beds	158 900 (Population: 39.3 million)
Hospital Beds per 1 000 inhabitants	4.1
Total health expenditure as a proportion of GDP	7.6%
Health Funding	Domin ated by general taxation but some compulsory insurance.
Health Insurance	Compulsory insurance
Primary Care	GPs mainly work within state health centres serving defined geographical areas.
Manpower	With an average of 4 000 newly qualified doctors entering the profession each year physician unemployment stands at 4.6 per cent.

Sweden

Number of Doctors	22 000
Number of Inhabitants per Doctor	395
Number of Hospital Beds	53 000 (Population: 8.8 million)
Hospital Beds per 1 000 inhabitants	6.1
Total health expenditure as a proportion of GDP	7.5%
Health Funding	Primarily by general taxation with general state subsidies state funds and health insurance making up the remainder.
Health Insurance	National health insurance covers all citizens and alien residents
Primary Care	Traditionally the Swedish health care system has been very hospital oriented but today one in seven doctors works as a GP. They are employed by the state to provide service from local health centres within specific primary care districts.
Manpower	The number of newly qualified doctors is restricted to 780 per year but with a further 150 immigrating to Sweden each year physician unemployment is quite high at 2.3 per cent.

The Netherlands

Number of Doctors	37 000
Number of Inhabitants per Doctor	424
Number of Hospital Beds	172 400 (Population: 15.7 million)
Hospital Beds per 1 000 inhabitants	11.3
Total health expenditure as a proportion of GDP	8.8%
Health Funding	Mostly from compulsory insurance schemes with some voluntary or private.
Health Insurance	Complex system of public and private insurance but moving towards a national scheme.
Primary Care	About 70 per cent of GPs work as single-handed free professionals but an increasing number are working in teams in group practices health centres and partnerships
Manpower	Medical unem ployment is 4.6 per cent but is declining as a result of new regulations on maximum weekly working hours and a trend towards part-time work among consultants. Projec tions show a deficit of physicians is likely to develop at the end of this decade

Executive Summary

Report of the Review Group on the Waiting List Initiative

Introduction

The Minister for Health and Children, Mr. Brian Cowen TD, established the Review Group on 9 April 1998 to examine the current Waiting List Initiative (WLI) for public in-patients and to make recommendations on how best to maximise its effectiveness. The Group was asked to report by the end of June. This is an Executive Summary only and should be read in conjunction with the body of the report.

Overall Conclusions

The Review Group believes that a series of immediate, medium term and long-term initiatives must be taken if waiting lists and waiting times are to be reduced substantially. There are no simple short-term solutions which, on their own, will have a significant impact. In addition, a satisfactory response must reach beyond the acute hospital services alone. The report makes a number of recommendations regarding organisational initiatives that could be implemented quickly, but these must be accompanied by an integrated set of medium to long term initiatives both within and outside the acute hospital sector.

Immediate-Term Recommendations: 1998

A number of recommendations, if accepted, could be implemented before the end of 1998. These relate to the assessment of hospital capacity, the improvement of information systems, steps to validate waiting lists and a number of short-term initiatives aimed at improving the operation of the system.

- Further study of hospital capacity is needed as a matter of urgency. Some hospitals have reached full capacity with existing resources in relation to elective work. Where staffing is an issue, these hospitals should be funded for the provision of appropriate temporary staff in target specialties, subject to certain conditions. Where physical capacity is an issue, favourable consideration should be given to developing, in the medium to long term, additional capacity in hospitals which demonstrate that their existing facilities are already appropriately utilised and fully committed.
- Agencies should be asked to review their information systems to ensure that they can maintain accurate and up-to-date WLI data and should be assisted if specific shortfalls are identified. The Department of Health and Children should develop and implement an improved IT system for recording and analysing national WLI data.
- Hospitals should carry out a bulk postal review of patients on their waiting lists where they have not done so in the previous twelve months. There should be an agreed protocol for periodic further reviews on a selective basis following this validation process.
- A set of short-term steps relating to the operation of hospital services should be taken. These include an improved flow of information between primary and hospital care regarding the status of patients on waiting lists; a continued move towards day case work; the appointment of bed managers and bed utilisation committees; agreement under each agency's service plan regarding the mix of public and private patients treated; and a written policy on planning the discharge of older patients and on liaising with community-based services.

Medium Term Recommendations: 1999

Report of Review Group on the Waiting List Initiative: Executive Summary

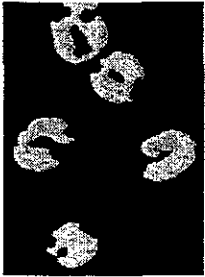
- The question of providing additional hostel or other short-term accommodation for patients who do not otherwise need to stay overnight in an acute bed should be pursued as a means of reducing unnecessary hospital stays.

APPENDIX 4



Criteria for the management of waiting lists and waiting times in health care

Health and Quality of life



Report

Demand for health care has been increasing as long as modern medicine has existed. Meanwhile the rising cost of health care has meant that most European countries have carried out health care reforms focused on cost containment and making health care systems more efficient and effective.

The gap between what health services are able to do and what they can afford to do has resulted in some patients facing delays (or waiting times) before getting specialist care and they may be put on waiting lists. It is important that the needs of patients and their relative urgency for admission, in terms of acceptable waiting times and their place on waiting lists, should be determined in a transparent manner using criteria that maintain the principles of equity, fairness and efficiency in health care services. This report describes the main causes of waiting lists and waiting times, their use in planning the admission and treatment of patients, the need to have accurate and accessible data and the importance of integrating waiting times issues into work to improve the quality, organisation and delivery of health care supported by the development of standard criteria based on transparency and equity.

- ✓ Preface
- ✓ Introduction
- ✓ Why waiting lists and waiting times exist in health care
- ✓ Information and data on waiting lists and waiting times
- ✓ Evaluation and appropriateness
- ✓ Consumer's role and patients' rights
- ✓ Legal and institutional setting
- ✓ Referral, selection criteria and procedure
- ✓ Management of waiting lists
- ✓ Modeling of waiting times and waiting lists
- ✓ Annex A : Examples of minimum data sets from Spain and the United Kingdom
- ✓ Annex B : Suggested outline for a hospital waiting list policy
- ✓ Annex C : Establishing health registers
- ✓ Recommendation No R (99) 21

France

Dr Pierre Lombrail, Faculté X, Bichat, Département de Santé publique, Paris.

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Sweden

Ms Marianne Hanning, Economist, Bromma.

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an outpatient only if they are seen first by a GP (General Practitioner) and then referred to the hospital or clinic. In others patients can access specialist care directly by making an appointment in a specialist's office or clinic. The Committee did not take a view on the issue of direct access to specialists but observed that waiting can exist both with and without direct access and that their conclusions would have different applications dependent on the mode by which patients access specialist care in member states.

■ Efficiency and effectiveness

The rising costs of health care is an issue in all European countries, and there is a strong focus on cost containment for health care services. Probably all European countries have made health care reforms concerning all parts of the health care systems during the last decade. Most countries have focused strongly on making their health care systems more efficient and effective.

- Efficient in that they produce the maximum volume of health services for the actual resources used
- Effective in that the right kind of health services are delivered

■ Quality of health services

There has been an increased focus on quality matters in health services, both as a result of rising standards of customer service in society, and as a result of cost containment in the health care industry itself. The difficulties in providing capacity in health services to meet in full the demand for maximum production of health services has strengthened the focus on quality issues. Total quality management methods have been adopted from the business community into the health services.

Waiting times are increasingly considered to be an important aspect of the quality of health services. This development has created a need for definitions concerning waiting times and waiting lists, in order to improve the delivery of services and to make it possible to compare waiting lists and waiting times within countries, between organisations and inside organisations over time. One approach in some member states has been to set out national standards for waiting times for some or all procedures. There have been some reservations expressed about whether such policies lead to distortions in clinical priorities with less urgent patients receiving treatment ahead of more seriously ill patients in order to avoid the breaching of waiting time limits.

■ Evidence Based Medicine

The growing emphasis on delivering the right kind of health services combined with the demand for greater quality in health services, has led to a stronger focus on evidence based medicine, in the sense that the continued use of diagnostic and treatment methods should be dependent upon an evaluation as to whether they have the desired effects. One of the results of this focus has been the Cochrane collaboration, which started in the United Kingdom and has spread internationally. «Meta-studies», where all research projects that have been performed in the different diagnostic or treatment methods are thoroughly evaluated, is one way this is being done. Medical technology assessment, which employs other tools to evaluate new (and sometimes old) diagnostic and treatment methods is another method used.

■ Whole systems approach

It is necessary to have a whole systems approach to health care spending, in at least two ways:

- A strong focus on waiting times in health care will easily lead to higher priority for acute illnesses. The result may be that surgical treatment and treatment of high focused illnesses such as heart infarction will get a high priority, while chronic and psychiatric care will lose in the prioritising process.
- The cost of health care has to be balanced with the needs of other parts of society. This is a necessity for society as a whole, but also for health care: The need for health care is in many ways a result of decisions in other parts of the society. For example, public hygiene, infectious disease and road traffic accidents.

■ The process of delivering health care

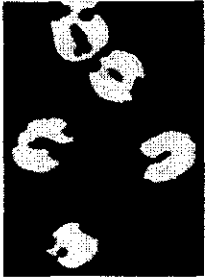
In all European countries there is a strong focus on making the health care production as efficient and cost-effective as possible. This has included improving the efficiency of hospitals through in part thinking of the organisation of hospitals in business terms as production facilities. In turn this gives an emphasis to the process of production. In most hospitals the production processes can be made more cost-effective. Also, waiting may arise because part of the process of delivering healthy care is not functioning correctly.

■ Prioritisation models



Criteria for the management of waiting lists and waiting times in health care

Health and Quality of Life



why waiting lists and waiting times exist in health care

Waiting times and waiting lists are important issues for health care in most European countries. Long waiting times are a problem for patients not only because of uncertainty but also because the state of the patient may deteriorate if not treated early enough. Short waiting times generally indicate that there are fewer problems in accessing care.

■ Waiting lists

Waiting lists can be seen as a hospital's working list or order book. They are necessary for the planning of hospital production processes, and constitute a means of prioritising care. In themselves, as a managerial tool, they do not constitute a problem. It is therefore important to be aware that waiting times constitute a problem to be managed. However the public and media frequently attach great importance to the number of people on hospital waiting lists and in the light of this public perception it is important for health institutions to pay close attention to the processes of delivering elective care.

Some commentators have stated - with support from economic theory - that waiting lists will always be a part of the health care system as long as the use of health care services in principle is free. In markets where prices regulate demand and supply a long wait can be avoided by paying a higher price. Since there are no real prices to regulate demand in public health care, waiting lists become an instrument for prioritising access to supply. However, others who have studied the issue see waiting lists as result of lack of resources. Another view is that waiting lists can occur as a result of bad management. As a result organisations that have long waiting times do not have clear enough goals about what is to be achieved, and thus have an inaccurate strategy to reduce the waiting lists. Variations in surgery rates between hospitals have led yet some researchers to explain waiting lists by differences in doctors' medical practice and different views of priorities and efficiency in the use of resources.

■ Multifaceted problem

There is no single reason why waiting times and waiting lists exist in health care. They are a multifaceted problem and are the result of a complicated interplay between demand and supply. If at present there are more people that demand a service than it is possible to supply with the present production capacity then waiting lists will generally occur. In addition if demand rises and supply is unchanged, waiting times and waiting lists will be longer. A rise in the supply in combination with a stable demand will give shorter waiting times and waiting lists. If supply is increased but demand also continues to rise then waiting times and waiting lists will probably not be reduced.

Waiting lists increase in seriousness if they are associated with a delay in accessing services. Large numbers waiting for a few days or weeks for treatment would present health systems with a scheduling problem that could be resolved through improved management. However, large numbers waiting for long times present a more fundamental challenge as it will require choices to be made over the priorities to be assigned between the different treatments that are being demanded.

Demand for health care has been rising as long as modern medicine has existed, and the causes for waiting lists have to a degree been a function of expanding demand for services. Supply has also expanded, but for some services, it has not been possible to support all of the demand without having some patients on waiting lists.

■ Demographic change

One of the more obvious reasons for demand to increase is demographic change, with the numbers and proportion of elderly people in the population increasing. The expectations for a good quality of life in old age are becoming higher. There is also a so-called medical paradox. That is, people who in previous years would have died of their illness now can live longer and they will have a need for medical services, such as hip replacements and cataract removal. Coincidentally, the waiting times for such treatments have generally been longer than the average in most countries.

cause is temporary problems with lack of trained or specially experienced staff. In small units it can be devastating if some specialised personnel are on sick leave for a long period.


» **Data**

Organisations that do not record data on waiting will have great difficulties in improving waiting time problems exists. Without adequate data it is not possible to. In the absence of data they may not be aware that a problem identify at what stages problems are occurring within the delivery of health care. Even the most basic data such as the numbers of patients registered for treatment, the date when referrals were received and when patients were seen in the clinic and listed for treatment would assist in the management of waiting times.

» **Summary of reasons for waiting lists and waiting times**

There are many origins of waiting lists, and if a unit has problems with long waiting times it can be related to one or more of the following conditions:

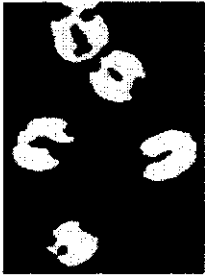
- The need for care has increased - caused by an ageing population (increased prevalence) and/or an increase in the incidence.
- Growing expectations and demand.
- New technologies leading to widening indications for treatment and an increase in demand
- Managerial or administrative shortcomings - decreasing productivity.
- Logistic problems - 'bottlenecks'.
- Absence of data
- Decreasing resources.
- Medical practice - priority setting.

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Criteria for the management of waiting lists and waiting times in health care

Health and Quality of life



Evaluation and Appropriateness

In addition to assisting in the management of the admissions process waiting lists should be reviewed in order to monitor the appropriateness of referrals and indications for which procedures patients are waiting.

A number of approaches can be taken to evaluate the impact of waiting on individual patients and the appropriateness of health care. Examples of these include:

- reviewing the number of potentially avoidable elective hospitalisations. These are a useful indicator to monitor access to care (inequity and inefficiency).
- comparing waiting times of procedures to take into account rates of appropriateness as a high rate of inappropriateness may be a big factor causing unusually long waiting times.
- choosing sentinel health events and monitoring their incidence to assess whether any delay in accessing care had been encountered and the extent to which this was responsible for any avoidable health damage;
- checking the stage of the disease when patients are added to the list. This may be an indicator of the performance of the referral process and of the equity of access. The less advanced the course of the disease, the better the referral process.
- analysing waiting times according to socio-economic characteristics of the patients to evaluate the accessibility for vulnerable groups.

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are not employed for whatever reason or those that are not getting paid for their work. Employers' and third party interests alone should not entitle a patient to priority for admission. However, despite ethical agreement on this principle it is hard to analyse this in absolute terms since the structure of insurance systems and the legal basis for accessing care differ from country to country. These are serious issues for equity and equitable access in health care. There is a need for research of these issues, including any arrangements for regulation, within member states and across Europe.

■ Quality of life

Priority for treatment should not be based purely on the nature of a patient's disease and issues about the quality of a patient's life should also be considered. In this context the quality of life relates to an individual's ability to carry out the activities of daily living and to live an independent life. The application of strictly medical criteria needs to be accompanied by an assessment of the whole person. This requires an examination not only of medical and technological issues, but also psycho-social and psychological ones. This should be a part of considering the priority for treatment and also for long term care. All health care professionals - medical, nursing and therapy, have a role to play in helping with assessing a patient's condition. These assessments also need to be, as far as possible, based on objective and transparent criteria that are evidence based.

■ Transparent and independent information

Patients and consumers of health care are entitled to have adequate general information on waiting lists and waiting times in specific settings. This should include access to individualised information about their own ranking on waiting lists. Information at an institutional level should be transparent - but without allowing individuals to be identified to third parties - and available to the general public, consumers, patients, governments and decision makers as well as insurance companies and health care providers. As well as the management and planning uses for such information that are covered elsewhere in this report there is great potential to use waiting list/time information to enable consumers to make deliberate choices about the options available to them for treatment. To assist this, information needs to be accessible, standardised and adapted for individual users and intermediaries. It also needs to be compatible with registration systems used within individual health systems.

Providing such information will help serve organisational goals for developing health care systems by promoting patient and consumer involvement. The Committee noted the experience reported by the Scandinavian countries and the UK where data have been developed and made available publicly. These experiences have shown the complications of explaining and interpreting the data to the media, general public and individual consumers. However, citizens should be able to know about these important aspects of health care in their countries.

Organisations representing patients and consumers should be involved in the dissemination and interpretation of waiting list information and in monitoring capacity problems. Citizens and patients should be able to get guidance and assistance when interpreting waiting list/time information for their personal use. Patients and their representative organisations should also be able to examine information on waiting list policies. The role that governments and insurance companies will play in the dissemination of this information will depend on the nature of the insurance system in each country. The provision of information to the public is another area that would benefit from research and exchanges of finding between countries.

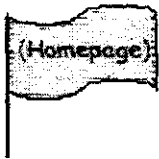
■ Conclusions

The management of waiting times and waiting lists can be considered from a medical, organisational and financial point of view. Many ethical and legal aspects are also involved. These points of view represent their own sets of values and modes of operation. By definition there is a conflict of interests. When analysing what interest or scope will prevail the patients' "frame of reference" should be an aspect of main importance. This should be linked to political and legal fundamentals of our western health care systems -solidarity, good quality of care, freedom of choice and right to know. Ranking on waiting lists and priority primarily should be put in terms of patients' rights on the "individual" and on the "collective" level.

Equitable access to health care:

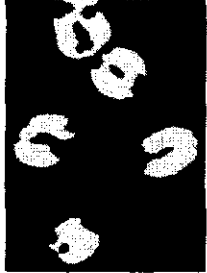
Patients' needs and urgency in terms of acceptable waiting time and ranking on waiting lists should be determined on the basis of fair referral and urgency according to:

- medical criteria compared to personal condition and risk factors (evidence-based)
- individual components such as emotional and certain psycho-social criteria;
- quality of life



Criteria for the management of waiting lists and waiting times in health care

Health and Quality of Life



Legal and institutional setting

Access to hospital and the maintenance of waiting list records will need to be managed within the existing framework of national legislation of member states that govern civil rights and issues such as data protection.

An approach taken by some countries has been to set out the standards expected from hospitals over the waiting time for an outpatient appointment or inpatient treatment. The Committee found that in most, if not all, cases these standards were not contained within legislation and therefore were guidelines to be followed by the health system rather than legally enforceable rights. Maximum waiting time limits can form part of a strategy to reduce waiting times and if they are pursued then a view needs to be taken as to whether they should be left to local discretion by institutions or a national set of limits agreed.

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The key decisions about priority are made when doctors assess patients and decide whether to admit them or not. Systems have been developed in some member states to assign a rank or score for individual patients to help assist in setting priorities on waiting lists. These have generally been developed at local level although a national exercise has been carried out in Norway (Lønning 1 and 2).

In developing standard criteria for the admission of patients to hospital, and by extension on to waiting lists the following points could be considered:

- levels at which priorities will be set: national, regional, local, institutional, clinician;
- if any services are not to be provided;
- whether a description of the main prioritising mechanisms and the agencies involved in deciding priorities for treatment decisions is needed;
- the width of public discussion, information and counselling about what services are to be provided
- proposals for future action.

■ Example from the literature

The Committee did not undertake a full literature review. However, the country reports annexed to this report provided a substantial amount of information on developments within member states. In addition, the members of the Committee provided further papers and articles that were circulated to the Committee for consideration. An example of developments in priority setting from the literature include the following from Salisbury (England).

Salisbury District Hospital

Variables used for ordering waiting lists:

- Progress of disease
- Pain or distress
- Disability or dependence on others
- Interference of disease with normal occupation
- Time spent on waiting list

The first four variables must be improvable by surgery.

Each variable is scored on a scale of 0 to 4 as patients are assessed in out-patient clinics and an overall score is generated.

BMJ, p. 811 1995.9.23

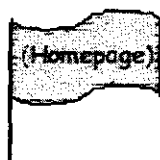
■ Developing criteria in Norway

The second Norwegian prioritisation report in 1997 (Lønning 2) included several criteria for consideration in the management of waiting lists.

The committee proposed the following division of priority groups:

- Basic health care
- Supplementary care
- Low-priority care
- Forms of care/treatment that have no place in publicly-financed health care

An example of this is the suggested criteria for what they call «Basic Health Care» and «Low Priority Care» is



Criteria for the management of waiting lists and waiting times in health care

Health and Quality of Life



Management of Waiting Lists

Improved management of waiting lists requires an understanding of the relationship between the demand for a service and the rate of supply. This understanding requires the development of information systems which not only can record the numbers of patients waiting for admission but also enable demand and supply for particular services to be monitored. Improving waiting times is not a one-off process of clearing a backlog of waiters but an ongoing project to balance demand for elective care with supply of treatment.

Waiting lists can serve as a formal record of patients identified as needing assessment or treatment. They can also be used as a statement of known demand for surgical or other treatment when planning the deployment of hospital resources.

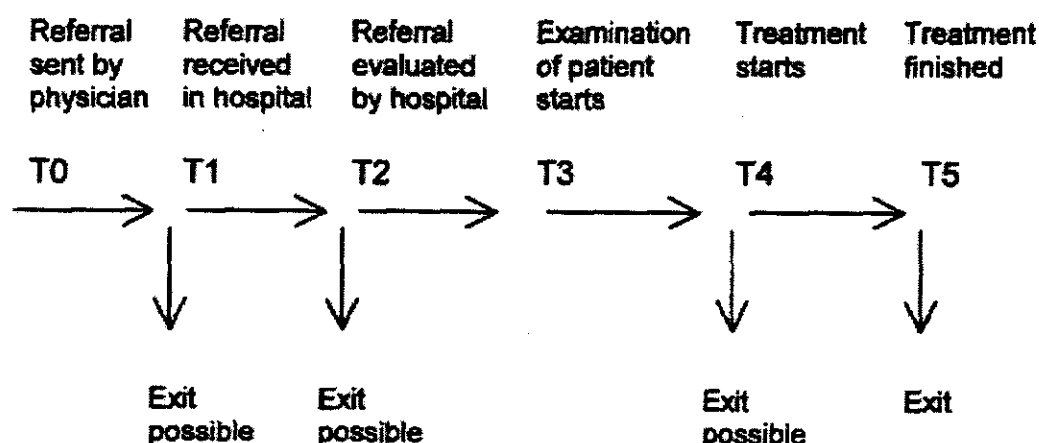
A waiting list policy

Delays in accessing health care are of considerable importance to the public and reflect poorly on health care providers. Provider organisations should ensure that access issues are addressed at Board level and responsibility taken by the Chief Executive. Organisations should have an explicit policy for the management of waiting lists and responsibility for its implementation should be given to a senior manager or clinician.

The organisation's waiting list policy should be part of the hospital's quality assurance programme. It should include goals and objectives as well as covering details of the administration and management of waiting lists. The policy should include clear statements about all major aspects of administering and managing waiting lists. Suggested topics for inclusion in a policy are given in [annex B](#).

The scope of waiting times policies need to be considered. They should cover both the management of access to outpatient consultations for diagnosis as well as inpatient admission for treatment. In addition, waiting times for investigations (e.g. radiology, angiography) need to be monitored. Waiting times can also exist for services not provided by doctors, such as speech therapy, or for health care appliances, such as artificial limbs and consideration should also be given as to how to manage these waiting periods.

Principles for waiting times to a hospital:



Waiting lists can be looked at in two ways: the experience of patients still waiting for treatment (prospective waiting) and the time waited prior to admission of patients already treated (retrospective waiting). Information on both types of waiting are needed to enable good waiting list management to take place. This is so that the number waiting on waiting lists can be monitored using prospective data and actual waiting times can be monitored using retrospective data.

or identify children separately. The date each patient was added to the waiting list should be recorded along with the details of the criteria used to determine relative clinical priority. These data enable waiting lists to be examined either in order of when patients were added to the list or their relative clinical priority. Both factors need to be taken into account when selecting patients for operating lists. It may be of help to identify which patients have admission dates and which patients are still without a date. Waiting lists can possibly include many different categories of patients:

- patients who have to wait because of general hospital resource constraints;
- patients with an advanced date of admission;
- patients who are having a further admission after an initial operation;
- patients whose admission has been deferred on medical or social grounds;
- patients sent home at the time of admission because of lack of beds or other resources;
- patients who could not attend when first offered an admission date;
- inpatients waiting for a transfer to another speciality (except emergency cases);
- patients who have a booked admission date.

A separate list should be held for planned repeat admission comprising those whose inpatient or day case treatment is planned over a series of admissions. Another deferred admission waiting list could be held including those who were unable to accept an offered admission date because of a medical or social constraint. Suggestions for establishing registers for waiting lists are contained in **Annex C**.

■ Maintaining waiting lists

Waiting lists, whether computerised or not, must contain sufficient information about each patient in order to enable their selection for treatment. Changes in patient details should be recorded promptly. An agreed set of data should be established and held for each patient.

A senior manager in each hospital should be made responsible for the administration of waiting lists. The hospital's waiting list policy should set out the systems to be used to administer waiting lists including the data to be obtained for all patients added to waiting lists. These procedures should be circulated to staff involved in the management of waiting lists and appropriate training provided. New staff dealing with waiting list administration should receive a structured induction programme in order that they can be familiar with the systems employed within the hospital.

■ Review and validation

Waiting lists should be reviewed at regular intervals and at least two times a year. The coverage of the review could include (for both outpatients and inpatients) patients who: have waited an excessive period of time (as defined locally), have turned down admission offers or who have been unavailable for admission for medical or social reasons. It is important to validate waiting lists in this manner to ensure that they reflect accurately the needs of patients. Validation can identify those patients who can be removed from a waiting list for a number of reasons: they have decided against having treatment, they have had the treatment elsewhere, they have moved away from the area or they have died. Validation can also be used to identify those patients requiring treatment who have not been added to waiting lists. Arrangements for review and validation should be recorded within the hospital's waiting list policy. GPs should be involved in the review process. Information could be given to GPs at frequent intervals listing the referring GP, patient, consultant, intended procedure, date when the outpatient referral was received, date entered on to the list and intended date of admission.

■ Publication

Waiting lists are important sources of information for patients and the wider public. Patient confidentiality needs to be protected but information on likely waiting times for individual specialists should be made available to patients and their General Practitioners. Such information can assist patients in choosing a specialist and guide GPs in referral decisions. Waiting times for particular procedures could be listed under each specialist.

■ Reporting waiting lists

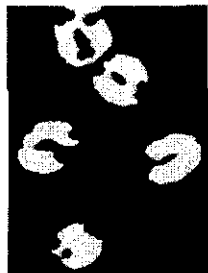
- based on agreed protocols, direct access to inpatient waiting lists can be developed for some procedures (e.g. for hernias, endoscopic examinations and diagnostic investigations), thereby avoiding waiting times for an outpatient consultation. Admission in these cases should normally be preceded by attendance at a pre-operative assessment clinic;
- separating elective admission beds from emergency admissions beds can reduce the possibility that elective patients will have to have their admission cancelled;
- joint reviews of cases between physicians and surgeons can eliminate periods of specialist to specialist waiting time, for example between angiography and assessment for cardiac surgery.

[1](#) [Previous page](#) | [Publications](#) | [Equity and access to health care](#) | [Health and ethics](#)



Criteria for the management of waiting lists and waiting times in health care

Health and Quality of Life



Annex A : Examples of Minimum Data Sets

from Spain and the UK

SPAIN: Minimum data set

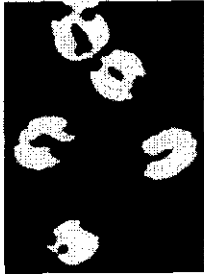
Surgical waiting list data record 1997	
Patients registered at WL	Operations and removal from the WL
Institution number	Date of removal
Patient number (clinical record no.)	Reason of removal
Gender	Admission in case of surgical treatment
Date of birth	
Date of registration	
Specialism	
Waiting list diagnosis code	
Literal diagnosis	
Surgical procedure code	
Literal procedure	
Clinical priority	

United Kingdom (England): Waiting list minimum data sets



Criteria for the management of waiting lists and waiting times in health care

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Annex B :

Suggested outline for a hospital waiting list policy

■ Purpose

- Goals and Objectives
- Links to other policies (e.g. quality assurance, clinical effectiveness, communications, admission and discharge)
- Definition of waiting lists and waiting times
- Purpose of waiting list policy

■ Responsibility

- Identification of managers and clinicians responsible for implementing policy

■ Scope

- Services covered by the policy.

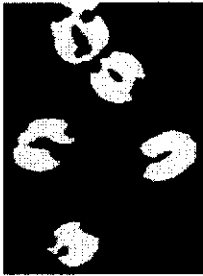
■ Planning

- Protocols agreed for referral and admission agreed with local GPs.
- Booking of patients for outpatient appointments, including arrangements for handling referrals from GPs.
- Criteria employed for assigning priorities to patients added to waiting lists.
- Booking of patients for admission.
- Style and purpose of Information to be provided to patients added to waiting lists
- Criteria to be used on selecting patients from waiting lists for admission.
- Arrangements for notifying patients of admission.
- Handling patients who do not attend.
- Administrative review (validation) of waiting lists.
- Arrangements for informing GPs.



Criteria for the management of waiting lists and waiting times in health care

Health and Quality of Life



Annex C :

Establishing health registers

Registers of health are established in order to give the responsible health authorities as well as the hospitals comprehensive information on activity, waiting lists and waiting time. The information in the register can be used to make comparisons between the regions, but is not intended as a tool for making administrative decisions on individual patients.

A register can include information on e.g.:

- Municipality
- Hospital
- Department
- Treatment
- Date of referral
- Way of referral
- Referral diagnosis
- Date of examination
- Examination diagnosis
- Periods of passive waiting (waiting due to circumstances specific to the individual patient)
- Date and reason for leaving the waiting list

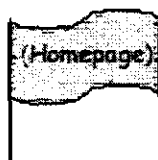
Before the register is established it is necessary to determine the purpose of the register. This analysis must both determine the purpose of the register today, but also try to predict for what purposes the register can be used in the future. This process is important in order to find out which variables to include in the register. To avoid lack of time-consistency it may be better to include variables with potential importance from the very beginning, instead of implementing them when the need is apparent and thereby suffer a loss of time consistency. However as every new variable raises the cost of collecting the data, variables without imminent or potential use should be avoided.

Managing the register

A health register can be a useful tool for many types of users and can serve as basis for medical-, administrative- and statistical purposes. In order to make the register available for different user groups, it is recommended that the register be placed under a central authority. The central authority is in charge of the day-to-day administration of the register. The responsibility for the data collection should however be placed under the local authorities.

Security issues:

In administrating the register, the central authority must follow a number of rules ensuring the safety of the data.



Recommendation No R(99)21

Health and Quality of Life



Recommendation No R (99) 21 of the Committee of Ministers to member states on criteria for the management of waiting lists and waiting times in health care

(adopted by the Committee of Ministers on 30 September 1998, at the 681st meeting of the Ministers' Deputies)

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe,

Considering that the aim of the Council of Europe is to achieve greater unity between its members and that this aim may be pursued, inter alia, by the adoption of common action in the public health field;

Bearing in mind Article 11 of the European Social Charter on the right to the protection of health;

Recalling that Article 3 of the Convention on Human Rights and Biomedicine requires that Contracting Parties provide "equitable access to health care of appropriate quality";

Noting the relevance of the World Health Organisation's Health 21 programme for the European region;

Having regard to Recommendation No. R (97) 17 of the Committee of Ministers on the development and implementation of quality improvement systems (QIS) in health care;

Considering that the collection of medical data raises special concerns with regard to data protection, especially where the data are to be collected or used for purposes other than immediate health benefits to the individual;

Having regard to the Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data (ETS No. 108) and to Recommendation No. R (97) 5 on the protection of medical data;

Considering that waiting lists and waiting times have become used increasingly as benchmarks of accessibility to health care and of the overall effectiveness of the health care system;

Aware that waiting times and waiting lists give focus to particular parts of the health care system, mainly elective surgical care;

Aware that waiting lists and waiting times may appear when the demand for health care exceeds availability;

Aware that the final objective of a health care system should be to eliminate both undue delays in access to health care and undue waiting lists altogether;

Considering that policies to address waiting times will need to reflect the relative priorities for achieving improvements in the whole health system;

Conscious of the differences between member states as far as the size of the problem and approach to the management of waiting lists and waiting times in health care are concerned;

Recommends that the governments of the member states:

- review the existence and role of waiting lists and waiting times in their health care systems; and, where necessary,
- develop comprehensive and coherent strategies for the management of waiting lists and waiting times in health care, taking into account the criteria set out in the appendix to this recommendation and the principle of equity in access to health care;

investigated before any action is taken to reduce them or to allocate additional funding. Before such action is proposed, long waiting times should be analysed and any bottlenecks within the provision of care addressed through appropriate action by clinicians and hospital staff.

■ **Criteria for assessing and treating patients**

Equity

7. Within secondary care, priority should be accorded to patients needing emergency admission but policies should also be in place to improve access for patients requiring elective diagnosis and treatment. Distributions of waiting lists and waiting times are important benchmarks of equity in health services. The central principle of access to care irrespective of the client's ability to pay should be taken into account. Access to elective care should be based on agreed criteria, and if patients are placed on waiting lists then this should be on the basis of standardised measures that can be used within all specialities and, ideally, for all procedures. These criteria and measures should be agreed at national level through an open and consultative process

Registration of patients on to a waiting list

8. All patients referred for diagnosis or for whom a decision to refer or to treat has been made should be registered by the relevant clinic or hospital and the date of the referral or decision recorded.

Consideration should be given to developing a standardised minimum data set for registration within member states that is consistent across all providers and specialities, with data ideally at the level of individual diagnoses and procedures. This should be in accordance with national and international policies applying to the collection and processing of health data

9. Once a decision to treat patients has been made, all patients should have a chance of being treated. To give a patient a place on a waiting list means a commitment to give care to that patient.

10. Patients should not be placed on a waiting list as a precautionary measure, that is, on the grounds that they will probably need treatment at some time in the future, and waiting lists should not be used as a means of gaining time.

11. The patient must have given her or his consent to be scheduled for treatment before being put on a waiting list.

Criteria for admitting patients from waiting lists

Priority must be given to patients with the greatest need for services, but waiting times should not be so long that the patients' health is at risk of deterioration. Doctors' decision-making on the individual patient's priority should be supported by nationally agreed guidelines on the criteria to be used in choosing patients for admission in order to maintain the principal goals of equity, fairness and efficiency in health care services.

13. Patients' needs and relative urgency for admission in terms of acceptable waiting times and order on waiting lists should be determined transparently, respecting the patient's preferences and developing and employing criteria that address the risk of deterioration to a patient's clinical status and their quality of life.

14. These criteria need to take account of the fact that need and urgency should never be determined on the basis of race, sex, religion or socio-economic status. Age should not be used to determine priority and should only be taken into account as an aspect of a patient's general medical condition and as a risk factor for particular treatments.

Monitoring waiting lists and waiting times

15. The different levels of organisation in health care do not have the same requirements with regard to necessary information systems to monitor waiting lists and waiting times. These systems should collect data needed to follow up and evaluate policies, and provide information about the past and current waiting list situation to all parties involved in health care decisions, that is:

- the public;
- patients;
- staff.

16 Systems developed to collect data on waiting lists and waiting times need to include arrangements for regular

- hospital level;
- department (speciality) level;
- if possible, diagnostic level.

23. Organisations representing patients and consumers should be involved in the interpretation and dissemination of waiting lists and information on waiting times as well as in monitoring of any problems with access to services.

Management of waiting lists and waiting times

24. Policy recommendations should be developed for the management of waiting lists and waiting times on different organisational levels in the health care system. In the policy document the following issues should be tackled:

- goals for the accessibility of care and access to waiting lists;
- responsibility for the application of waiting time policies;
- acceptable waiting time limits, depending on the speciality, the patient's state of health and diagnosis;
- definition of emergencies and urgent treatment, and the process to be followed;
- selection of patients for admission;
- the booking process;
- guidelines for priority-setting;
- communication with patients and referring doctors including a system for feedback from clients and patients;
- structure of the waiting lists, including necessary data;
- review and validation;
- publication and reporting of waiting lists and waiting times;
- how to handle patients who have been on a waiting list for a long time;
- recommendations on how to solve waiting list problems, that is, if objectives can not be reached, what action should be taken;
- arrangements for the evaluation of the policies applied.

Organisational development

25. Policies for waiting lists and waiting times should identify the responsibility within institutions for managing access to services as well as action to be followed to identify and then address any problems in the process that lead to delays in treatment of patients. A senior member of staff should hold clear responsibility for the management of waiting lists. The involvement of clinicians in the management of access to elective care is important. Work to improve waiting times must examine the organisation and functioning of health care systems and can not be confined to data collection alone.

26. The nature of waiting times and their management should be a part of the undergraduate and postgraduate health care education programmes in European countries. This should be accompanied by information about the principles of prioritising patients who need care.

Further research into waiting times and waiting lists in Europe

27. Research on a pan-European basis should be conducted to enable countries to share knowledge and experience about reducing waiting lists and waiting times in health care. There should be joint research projects into waiting times in European countries, the results of which could be used in different countries. This type of

HEALTH POLICY STUDIES No.2

**THE REFORM
OF
HEALTH
CARE**

*A Comparative Analysis
of Seven OECD Countries*

OECD
PARIS 1992

Chapter 2 goes on to discuss some main sub-systems of financing and delivery of care. The seven health care systems themselves and their recent reforms are described in some detail in Chapters 3 to 9. Chapter 10 contains statistical comparisons on the growth and performance of the health care systems in the seven countries. Chapter 11 compares and appraises the reforms, and Chapter 12 is devoted to policy conclusions.

COMMON OBJECTIVES OF HEALTH CARE POLICY

The seven countries appear to share similar objectives in their health care policies. Stated briefly, and drawing on Barr (1990), these include:

Adequacy and equity in access to care: there should be some minimum of health care available to all citizens and treatment should be in accordance with need, at least in the publicly financed sector.

Income protection: patients should be protected from payments for health care which threaten income sufficiency and the payment for protection should be related to individuals' ability to pay. This will involve at least three types of transfer: insurance (the need for care is unpredictable); saving (the elderly use more services than the young) and income redistribution (the sick are often the poor).

Macro-economic efficiency: health expenditure should consume an appropriate fraction of GDP.

Micro-economic efficiency: a mix of services should be chosen which maximises a combination of health outcome and consumer satisfaction for the available share of GDP expended on health services (allocative efficiency). In addition, costs should be minimised for the available share (technical and cost efficiency). The benefits should take account not only of the health of the individual patient, but also of his or her satisfaction with the method of delivering the service, and of the health and welfare of others who are likely to be affected by the patient's condition. The costs should take account not only of the costs of provision but also of the value of the time of patients and their relatives, and of the costs of administration, regulation and tax distortions. Furthermore, dynamic efficiency should be pursued: that is to say, there should be a search for technological and organisational advances which raise the productivity of given resources.

Freedom of choice for consumers: freedom of choice should be available in public sector as well as in private sector arrangements;

Appropriate autonomy for providers: doctors and other providers should be given the maximum freedom compatible with attainment of the above objectives, especially in matters of medical and organisational innovation.

The last two objectives could be treated as means rather than ends: they are included here because they have some claim to be treated as desiderata in their own right.

It goes without saying, perhaps, that these objectives involve making judgments about values which will vary between and within countries. Also, some of these objectives conflict, some overlap, and opinion will vary as to the relative priority that should be accorded to achieving any one of them.

STRENGTHS AND WEAKNESSES OF FREE MARKETS

In many sectors of OECD economies, the objectives set out above would be met by reliance on the free market, combined with general measures of income redistribution. After all, the competitive market with income redistribution is, in many areas of the economy, the most successful way which has yet been devised for combining consumer choice, producer autonomy, economic efficiency and equity. In a competitive market, the consumer is motivated to balance the benefits gained from the consumption of goods and services against the price that has to be paid for them; the profit-maximising producer has an incentive to maximise the perceived worth of the product and to minimise the cost. Competition will ensure that prices are related closely to opportunity costs – at least in the long run. The value of output will be maximised for a given distribution of income.

It may be added that, in a world with frequent technological and organisational change, allowing temporary monopolies created by innovations can help to spur dynamic, efficiency improvements. The competitive market might seem, at first glance, to be entirely appropriate for health care, too. Health care is mainly a personal service which can be provided by potentially competing professionals and private institutions. Few, important production externalities occur except in the case of infectious diseases which, with the exception of AIDS, are of dwindling importance.

Finally, governments have often chosen both to finance and to provide health care for vulnerable groups or whole populations, with salaried doctors employed in public clinics and hospitals. This can be combined with more or less autonomy on clinical matters for the doctors. These arrangements have enjoyed a mixed history in different countries. At best, they seem to be capable of supplying good quality health care according to clinical need, financed at a reasonable cost. However, they are frequently attended by waiting lists and seem to encourage a brisk and impersonal style of service. At worst, the result is over-loaded and low-quality services which are supplied by ill-motivated staff in shabby premises. It is also not unknown for publicly financed and provided health services to be corrupted by private, "under the table" payments from patients to professionals. While this report was being written, the former communist countries of Central and Eastern Europe were beginning to dismantle their monolithic and autocratic, state-financed and provided health services in favour of more liberal arrangements. The case of Eastern Germany is considered in Chapter 5.

CURRENT PROBLEMS WITH THE FINANCING AND DELIVERY OF HEALTH CARE

The seven countries in this study have already had much experience in trying to devise health care financing and delivery arrangements which combine the strengths of the market with the strengths of government institutions, while avoiding the weaknesses of both. The mixture of arrangements which they have chosen have enabled them to achieve some of their policy objectives for health care. Nevertheless, to judge by the scale of the reforms introduced in the 1980s, not to mention the policy debate which surrounds them, most of the governments are not, as yet, satisfied with the performance of their health care systems.

All seven countries have achieved universal, or near universal, access to basic health care of a high quality, which is largely independent of patients' ability to pay. Most are now enjoying some success in controlling costs. However, despite these achievements, all seven continue to wrestle with a range of difficulties which concern the efficiency, cost and equity of health care delivery and finance. These vary in their incidence between countries but they include:

- Continuing rapid growth of health expenditure in some and pressures for higher expenditure in all countries;
- Concern about excessive or unnecessary care and over-medicalisation of social problems in some countries;
- Concern about inadequate care and impersonal care and lack of responsiveness by providers in some countries;
- X- Continuing growth in queues and waiting times in some countries;
- Evidence about large and inexplicable variations in activity and unit costs between and within countries;
- Concern about lack of co-ordination among providers in most countries;
- Evidence about remaining inequities in health, in access to health care and in payment for health care in several countries.

Some of the circumstances which are believed to be causing these problems lie more or less outside the control of governments. Others appear to lie within the control of governments and to be amenable, at least potentially, to the process of reform. Others seem to occupy an intermediate position.

More or less outside the control of government are:

- Variations in the health of individuals which are the result of biological, cultural and social factors;
- The ageing of the population, which tends to raise costs because the elderly are the heaviest users of services;
- Rising expectations about standards of medical care which affect publicly funded services; and
- The continuing advance of cost-increasing medical technology.

In varying degrees, these affect all OECD countries.

The continuing paucity of information on the final product of health services – in other words, how health services affect health itself – is one area which seems to lie only partly within the competence of government. This is perhaps the main obstacle to the better management, and indeed to the reform, of health care systems. Whether this arises from difficulties with the technology for measuring health outcome, or from the way in which clinical information is monopolised by the medical profession, is open to debate. Again, lack of information about the effectiveness of health services affects all OECD countries.

Among those factors which seem to lie mainly within the competence of governments and which can be tackled by reforms are:

Chapter 2

SUB-SYSTEMS OF FINANCING AND DELIVERY OF HEALTH CARE

INTRODUCTION

At first sight, the seven countries in this study display great diversity in their methods of financing, organising and regulating health services. They differ in the extent to which they rely on out-of-pocket payments, private insurance, social insurance and general taxation for financing health services. They differ in the methods by which third parties pay providers. They differ in the extent to which the government itself has taken over the provision of health services or has left provision in private hands. And they differ in the extent to which regulation has been of the command and control type or has been devoted to promoting, as well as to channelling, market forces or quasi-market forces. These differences might appear to limit the usefulness of a comparative study of their health care reforms.

However, closer examination suggests that beneath this apparent diversity, the seven health care systems are made up from a short list of sub-systems of finance, payment and regulation, a few of which tend to dominate. A useful step towards understanding the national systems and their recent reforms is to differentiate these sub-systems, to identify the few which are dominant and to establish some hypotheses about their strengths and weaknesses against the objectives for health care which we discussed in the previous chapter.

The models suggested by Evans (1981) can be used to identify the sub-systems, and, indeed, to describe the whole health care systems of the seven countries later on. The models summarise alternative interactions between five principal sets of actors in health care systems: *a*) the consumers/patients; *b*) the first-level providers (such as general practitioners, or pharmacists supplying over the counter medicines); *c*) the second-level providers (such as most hospital services, and pharmacists who supply prescribed drugs); *d*) the insurers (or third-party payers); and *e*) the government in its capacity as regulator of the system. The main interactions between the five include: provision of services; referrals from first- to second-level providers; payment for services; payment for insurance; payment of insurance claims; and various forms of regulation by government. The models involve considerable simplification, but they help us to identify certain key building blocks which are found commonly across countries.

SUB-SYSTEMS OF SOURCES OF FINANCE AND METHODS OF PAYING PROVIDERS

It is convenient to start by looking at the main sub-systems of sources of finance and methods of paying providers, before bringing in varieties of government regulation. We can identify two major sources of finance: voluntary and compulsory (or public); and four major methods of paying providers: out-of-pocket by consumers, without insurance; out-of-pocket by consumers, who are reimbursed from insurance; indirectly by third parties, via arm's length contracts; and indirectly by third parties, via budgets and salaries within an integrated organisation. One of the resulting eight combinations of finance and payment – compulsory, out-of-pocket payment – is hardly found in practice. The remaining seven models are:

- The voluntary, out-of-pocket model;
- The voluntary reimbursement (of patients) model (to avoid confusion the term “reimbursement” is used only in the sense of reimbursement of patients in this book; this corresponds with British usage, and with French usage *remboursement*);
- The public reimbursement (of patients) model;
- The voluntary contract model;
- The public contract model;
- The voluntary integrated model; and
- The public integrated model.

of macro-economic and micro-economic efficiency is in doubt. Whereas consumers will be fully cost-conscious and will generally enjoy choice of provider, it is not clear that consumer sovereignty will prevail or that effective competition will take place. This is because of the asymmetry of knowledge between patients and physicians, and the possession of collective monopoly power by the latter. The model is likely to be most satisfactory for minor and routine health expenditure.

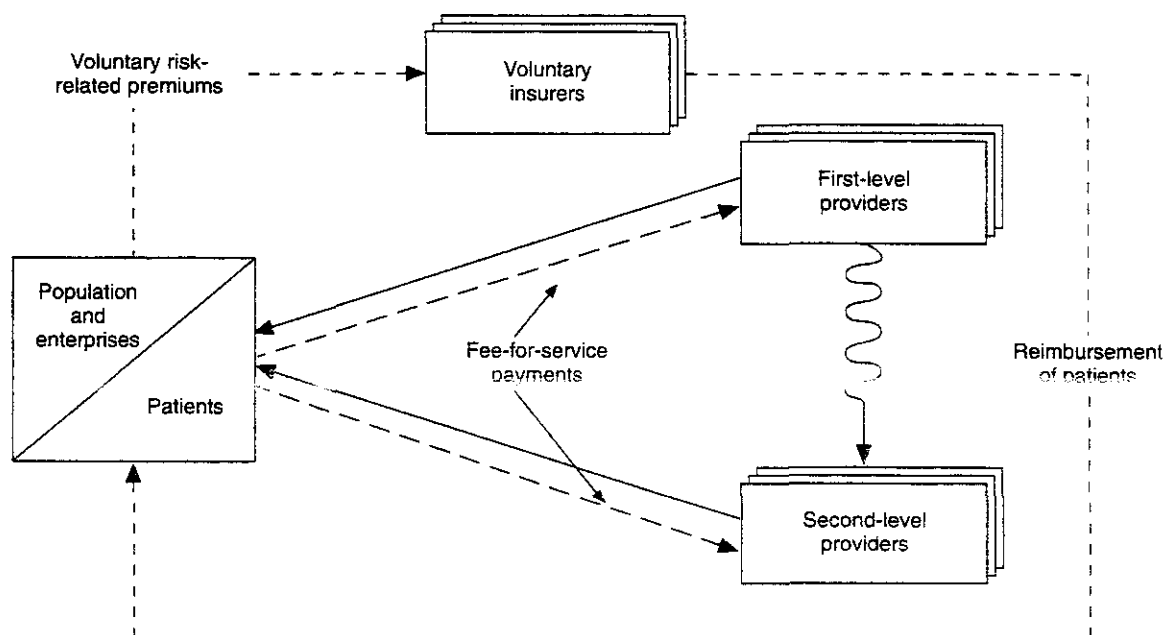
Given the prevalence of third-party payment for health services, the out-of-pocket model now plays only a supporting role in the health care systems described in this report. It is universally used for over-the-counter medicines, and for cost-sharing, especially for prescribed medicines. Private medical care consultations are often paid for out-of-pocket. In Ireland, over half of the population normally pays for general practitioner consultations out-of-pocket.

The voluntary reimbursement model

The working of private, medical care markets can be enhanced by the introduction of voluntary health insurance, but there tend to be unwanted side effects. Chart 2.2 shows "conventional" voluntary insurance of the indemnity kind, which involves reimbursement of patients for medical care bills, in part or in whole, and minimal interference with doctor/patient transactions of the kind described in Chart 2.1. There are: direct, fee-for-service payments to providers by consumers; competitive insurers; risk-related premiums; no connection between insurers and providers; and reimbursement of patients by insurers for medical bills covered under their insurance policies. There may well be cost-sharing between the patients and the insurers. A distinction can be made, within the consumers' box in the diagram, between the population which pays premiums and the consumers/patients who utilise services.

The voluntary reimbursement model will improve upon the out-of-pocket model to the extent that consumers can pool risks for unexpected medical care bills. There will be gains in welfare if individuals can exchange a certain premium for the uncertain prospect of either a higher income (if they remain healthy) or a financial loss (if they become sick and incur medical bills). However, these gains are eroded by administration costs which typically require 10 % to be added to the cost of actuarially fair premiums. Two other important drawbacks are associated with these arrangements.

Chart 2.2 Voluntary insurance with reimbursement of patients



contribution rates and cross subsidies between funds if solidarity is to be preserved. For this reason, sickness funds are not shown as multiple. However, there can be consumer-led choice between providers.

This model can be designed to achieve a desired level of equity in access to and payment for services at the cost of compulsory contributions. Otherwise, it tends to share the defects of its private sector equivalent – moral hazard, supplier-induced demand and a tendency towards high administrative costs. Again, moral hazard can be countered by compulsory cost-sharing (such as the *ticket modérateur* in France).

The French system in the 1950s resembled this model in some respects, although the State subsequently stepped in behind the sickness funds to negotiate fees centrally with the doctors and other independent providers. Both the Belgian and French social health insurance systems retain elements of the public reimbursement model.

The voluntary contract model

Private markets in Europe long ago developed voluntary health insurance arrangements which involved contractual relationships between insurers and independent providers which enabled these providers (but not others) to supply services wholly or mainly free of charge to insured members (Green, 1985 and Abel Smith, 1988). These were forerunners of those health maintenance organisations in the United States which contract with individual physicians or with groups of physicians. Chart 2.4 shows such a model, with services provided in kind to patients, competition among insurers, community-rated (flat-rate) premiums and direct fee-for-service payments or capitation payments from the third parties to the providers. Providers are shown as multiple using dotted lines, to draw attention to the fact that competition is led by the insurers rather than by individual consumers.

This model comes in various versions: the insurers may be controlled by consumers (as in the early European friendly societies); they may be controlled by doctors or other providers (as in contemporary Individual Practice Associations in the United States); or they may be controlled by private organisations which are independent of both consumers and doctors. The benefits of the scheme may cover primary care only, or they may cover both primary and hospital care. Two important features of this model are: that consumer choice is generally restricted to the contracted providers; and that the insurers have both the incentive and the means to

Chart 2.4 Voluntary insurance with insurer/provider contracts

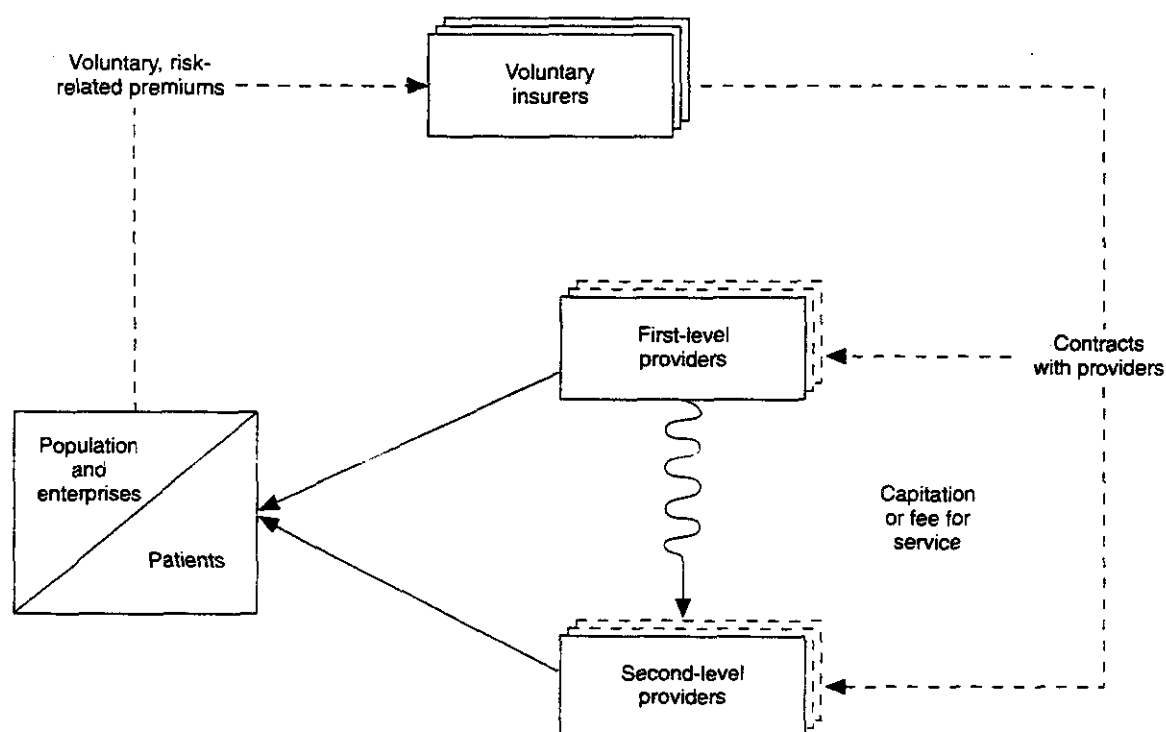
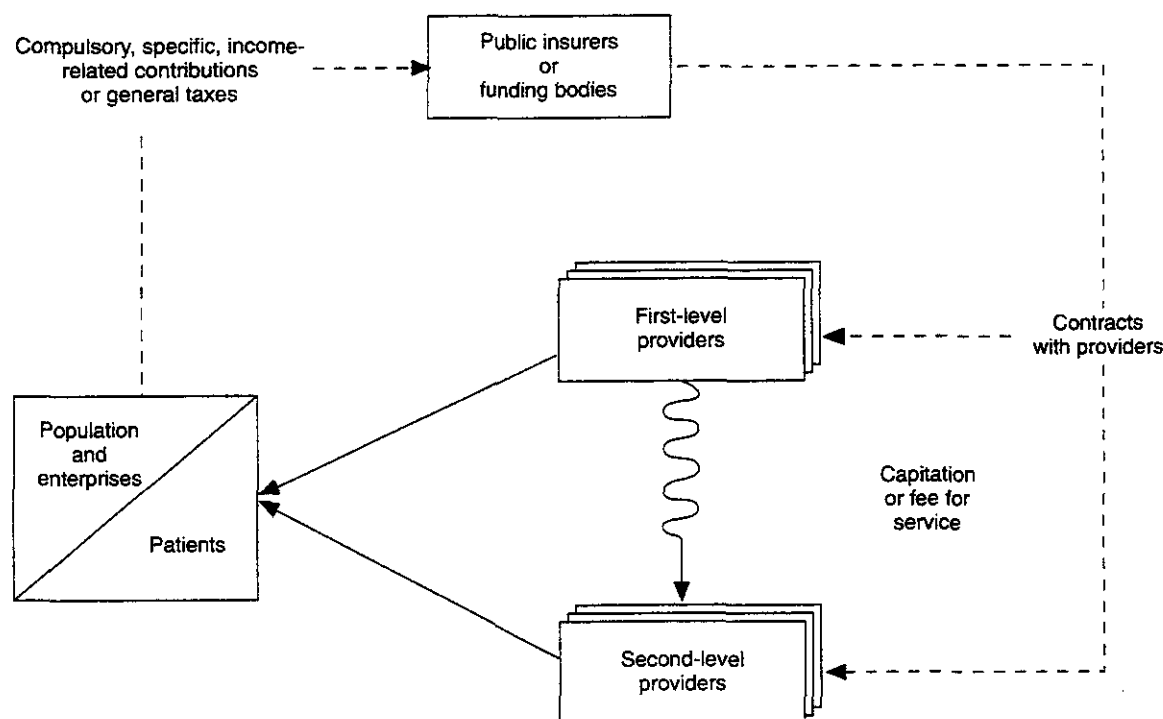


Chart 2.5 Compulsory insurance with insurer/provider contracts

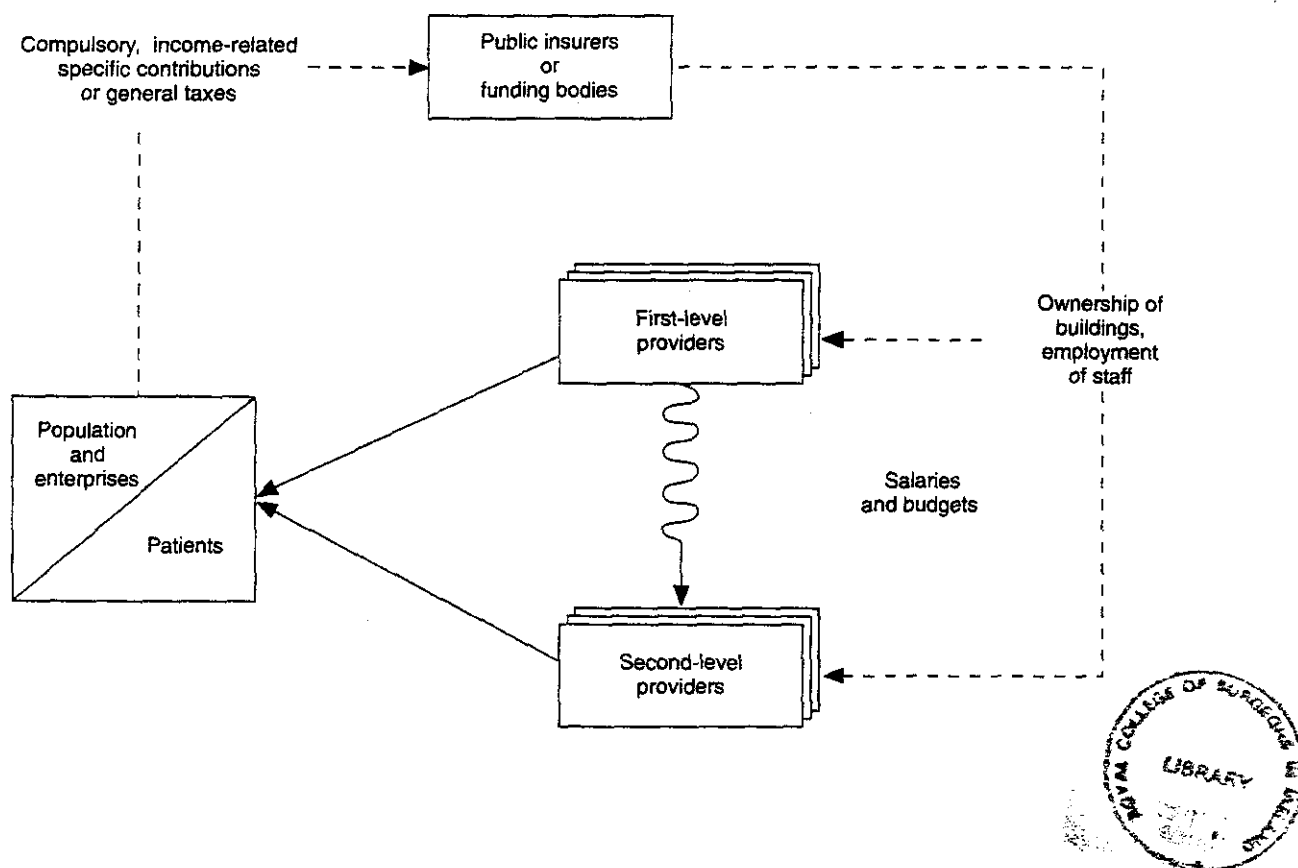


The voluntary integrated model

An early development in European private markets for medical care was that some groups of consumers as well as some insurers found it preferable to employ doctors on salary and to own their premises for primary care – and even hospital services – rather than to contract with independent providers. Later, these types of arrangements were rediscovered in the United States in what became known as the staff model of the health maintenance organisation. Chart 2.6 depicts the voluntary version of this model with: services supplied to patients in kind; competing insurers; voluntary, community-rated premiums; and vertical integration between the insurers and the providers, with salary and prospective budget payments to providers. Once again, providers are shown as multiple using dotted lines to indicate that consumers' choice of provider will follow, but be restricted by, their choice of insurer.

The voluntary integrated model preserves freedom of choice of insurer at the cost of restrictions on choice of provider. It restricts the managerial autonomy of doctors, although it can coexist with clinical autonomy. It possesses good potential for achieving macro- and micro-economic efficiency because there are: competitive incentives; good opportunities for managing the provision of care (through gatekeepers and the employment contract); and prospects for making administrative savings because of vertical integration. Although there are incentives towards under-service, these are counter-balanced by the need for the insurer to attract and hold the consumer in a competitive insurance market. However, as with the voluntary reimbursement and contract models, this model is unlikely to achieve the desired level of income protection or equity for vulnerable groups. This is because the acquisition of insurance will depend on ability to pay and there will be incentives for risk selection in a competitive market. The model was not popular with organised medicine in Europe and, in its voluntary form, failed to survive the establishment of compulsory national insurance schemes (Abel-Smith, 1988).

Chart 2.7 Compulsory insurance with integration between insurance and provision



model. Because it involves compulsion this model is capable of achieving universal coverage and the desired level of equity.

This is the dominant model in Spain and for public hospitals in France and in Ireland. It was, until recently, the model used for public hospitals in the United Kingdom. A totalitarian version was virtually the sole model in Eastern Germany before reunification.

Mixed systems

As we will see in Chapters 3 to 9, the seven countries all have health care systems which are mixtures of several of these seven sub-systems of financing and delivery of health care. There are good reasons for this. Voluntary payment systems can act as safety valves for compulsory systems. Moderate cost-sharing can mitigate the adverse incentive effects of generous third-party coverage, particularly in the reimbursement model (van de Ven, 1983). The public contract model has been popular for ambulatory medical care, presumably because it helps to preserve the independence of doctors. The public integrated model has been popular for hospital care, partly because it favours control of costs. However, all of the national systems are dominated by just one or two of the sub-systems.

First, the voluntary models have come to play a minor or supplementary role in all of these countries except the Netherlands, where the private reimbursement model still played an important part at the end of the 1980s. Second, among the compulsory models, the public contract and public integrated models are dominant, complemented by, at most, minor cost-sharing. Although Belgium and France still rely upon the public reimbursement model to some extent, this has been blended with the public contract model or, in the case of public hospitals in France, overridden by the integrated model. Germany, the Netherlands and, more recently, the United Kingdom, rely mainly on the public contract model. Spain relies mainly on the integrated model. Ireland relies on a mixture of the two.

that any one model performs better than any other in this respect. Uncertainty about health outcome is an obstacle which all governments face in their attempts to improving the performance of their health care systems.

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Chapter 6

THE REFORM OF THE HEALTH SYSTEM IN IRELAND

INTRODUCTION

The Irish health care system contains a unique combination of public and private institutions. This chapter describes the way health care is financed and delivered in Ireland and the reforms to the system in the 1980s. It goes on to discuss the recent growth and performance of the system and some of its strengths and weaknesses.

Although voluntary insurance plays an important role, the main source of finance is general taxation and, as a consequence, the government has considerable discretion over the rate of growth of expenditure. Following rapid growth in health expenditure during the 1970s and a deterioration in the Irish economy, the government decided to make sharp cuts in real health expenditure in the 1980s. This led to mounting public concern and controversy. In response to this, the government appointed a Commission on Health Funding in June 1987 which reported in September 1989 with a number of proposals for major reforms, put into effect in 1991. The chapter concludes by describing and assessing the recommendations of this Commission.

HEALTH CARE SYSTEM DESCRIBED

So far as financing of health care is concerned, the Irish system is an example of the social assistance model. That is to say, the poorest one-third of the population (category I) has been given full eligibility for free health services funded out of general taxation. Until 1989, half of the population with middle incomes has been given more limited eligibility for free services, and the richest 15 % has been given still more limited eligibility. Within the public system, general practitioner services are supplied under the contract model, and hospital services are supplied under the integrated model. Because of limited eligibility, private expenditure plays an important role in the system. Private health insurance is available on a voluntary basis, and has been taken up by about 30 % of the population. It is available, however, only from a single, public insurer, the Voluntary Health Insurance Board. On the delivery side, there is a mix of public and private provision with independent general practitioners and a mix of public, voluntary and private hospitals.

The main features of the system can be depicted diagrammatically (see Chart 6.1). At the bottom left of the diagram is the population, most of whom become patients in any one year. At the bottom right of the diagram are the providers who supply health services to patients. At the top of the diagram are the third-party payers. Service flows are shown as solid lines and financial flows as broken lines.

The providers have been separated into: public health services, pharmacists (retail chemists), general practitioners, voluntary general hospitals (some of whose beds are private), public general hospitals (some of whose beds are private), public special hospitals (for geriatric, mentally handicapped and psychiatric patients), community health services (including home nursing, dental, aural and ophthalmic services), and private general and psychiatric hospitals. There are considerable flows of direct payments from patients to providers.

The third-party payers have been separated into the Department of Health and the Voluntary Health Insurance Board. Also shown are the health boards (of which there are eight) which fund and manage public services locally, and the General Medical Services (Payments) Board which funds general practitioners and pharmacists, for Category I patients, on behalf of the health boards. Most of the services which are funded publicly are funded through the health boards, with the exception of the voluntary hospitals which are funded directly by the Department of Health.

The financial flows usually involve separate, recurrent expenditure and capital grants, with the exception of those to independent practitioners, such as the pharmacists and GPs, which involve fees and payments which cover annuitised reimbursement for capital. Until recently, the Voluntary Health Insurance Board reimbursed its members for medical care bills on a charge basis for services covered under its policies. However, the Board is

now capping payments and paying most providers directly, with the result that some patients are themselves having to cover the extra billing.

RELATIONSHIP BETWEEN PATIENTS AND PROVIDERS

Everybody enjoys eligibility for a full range of modern health services, but the terms on which access to some of these services takes place varies according to eligibility and insurance coverage. The main distinction is between public and private patients. For example, about 40 % of consultations with GPs and 25 to 30 % of in-patient episodes in general hospitals are private (that is to say, fee-paying). The public share of ambulatory care billing is one of the lowest in the OECD (Poullier, 1990, Table 19). Clearly, access to private care depends on either ability to pay or insurance cover, which tends to be taken out mainly by middle and higher income groups.

All patients can choose their GP, but whereas private patients may switch doctors at will, public patients must register with a GP who participates in the public scheme and must apply to the Health Board for a change of doctor. GPs act as gatekeepers and they usually work on their own rather than in group practices. Tussing (1985) has estimated that 72 % of hospital expenditure and 98 % of the cost of prescription medicines is instigated directly or indirectly by GPs. He also observed that GPs in Ireland have much higher hospital referral rates than their counterparts in England. This may be because their practices are often single-handed. So far as expenditure is concerned, hospitals dominate and more than 60 % of doctors work in hospitals, either as consultants or as junior doctors. If the GP issues a pharmaceutical prescription, the patient usually takes it to a retail chemist for the drug to be dispensed, but in rural areas doctors are allowed to do their own dispensing. Private patients usually pay for prescriptions out of their own pockets (for the exceptions, see below) but Category I patients are entitled to free drugs. GPs' fees for private patients are set by the market, although there is no overt competition over price. Pharmaceutical prices are controlled, even for private patients.

Eligibility and insurance cover determine the terms on which access to health care takes place. Until recently, there were three categories of eligibility:

Category I: Adult persons and their dependants who are judged to be unable to arrange GP services for themselves and their dependants without undue hardship. In practice, they represent about 37 % of the population. They are eligible for the full range of publicly financed health services free of charge and they are given medical cards as evidence of this. The issue of a medical card depends mainly on a means test but chronic illness may also be taken into account.

Category II: All remaining adult persons and their dependants with income below a certain threshold (£16 000 in the 1988-1989 tax year). They represent about 48 % of the population. They are eligible for all publicly financed health services except free GP services and free prescribed medicines below a certain threshold level of expenditure each month, or in the case of certain chronic illnesses. In addition, they must pay £10 for the first hospital out-patient visit for any condition and £10 per day for the first ten days of public in-patient care in any one year.

Category III: Adult persons and their dependants with income above the threshold of £16 000, mentioned above. They represented in 1988 about 15 % of the population. In addition to the exclusions mentioned for Category II, they were not eligible for free hospital consultants' services or for free maternity and infant welfare services in the community. In addition, like Category II patients, they must paid £10 per day for the first ten days of public in-patient care in any one year.

Category II and Category III were combined in legislation enacted in 1991 to produce a two-category system which is currently in existence.

All citizens are eligible for free care, including in-patient care, for communicable diseases and certain chronic diseases, and for infant screening and child health examinations.

Turning to insurance cover, about 30 % of the population had health insurance policies with the Voluntary Health Insurance Board in 1987. The Board offers two main types of policy: broad policies which cover private specialist fees, private or semi-private hospital accommodation, and certain out-patient costs such as GPs' fees over a certain threshold; and narrow policies which cover only gaps in eligibility such as charges for public beds and hospital specialists' services. The great bulk of subscribers carry the first type of policy and they include many Category II individuals who are entitled to fairly comprehensive free public care.

The combination of the three categories of eligibility and the presence or absence of insurance cover meant that before recent reforms, there were at least six patient groups (see Table 6.2). During a typical episode of acute care, each group could face different financial incentives. Moreover, the methods by which doctors were paid

The Voluntary Health Insurance Board is unusual in that it is sponsored and directly regulated by central government, yet offers voluntary insurance. The Board was designed to provide a complement to tax-funded health services which concentrate on the less well-off (McDowell, 1989). It has a monopoly of voluntary health insurance which has enabled it to adopt community rating from the outset and, more recently, to exert monopsony power over providers. A fairly limited range of seven main policies are available (for details see Commission on Health Funding, 1989). Like most private insurance, cover is excluded for existing medical conditions for new subscribers and there is an upper age limit at 64 for entry. Membership of the VHI grew rapidly in the late 1970s and early 1980s before levelling off at about 30 % of the population in the mid-1980s. The VHI used to provide most of its benefits in the form of reimbursement of medical care bills. In recent years, however, it has switched to paying specialists and hospitals directly.

Health insurance premiums are eligible for income-tax relief at subscriber's marginal rate of tax which ranged from a standard rate of 35 % to a top rate of 58 % in the 1988/89 tax year (OECD, 1989). In addition, income-tax relief is available for certain unreimbursed medical expenses exceeding £50 in one year for an individual or £100 a year for a family. Expenditure on routine maternity, dental and ophthalmic care is excluded from tax relief. In 1988, tax expenditures accounted for 3 % of health expenditure.

RELATIONSHIP BETWEEN THE THIRD-PARTY PAYERS AND THE PROVIDERS

Until 1989, most GPs were paid on a fee-for-service basis for Category I patients. Fees have then been replaced by capitation payments, weighted by age, sex and distance from patient, supplemented by fees for a few, specified procedures. There are no practice allowances (akin to salary payments) in GPs' remuneration, unlike the payment system in the United Kingdom. A few GPs continue to be paid by salary. About 1 500 of Ireland's 1 800 GPs take part in the public scheme for Category I patients. Normally, there is a limit of 2 000 on a doctor's list of medical card holders. Doctors usually have discretion over whether or not they accept patients onto their lists, but, under certain circumstances, they may be assigned patients by the GMS (Payments) Board. Another 48 % of the female population is eligible for free maternity care, and participating GPs are paid by fee for service for such care. Fees and capitation payments are negotiated between representatives of the doctors and the Department of Health. The fees per item paid by the GMS (Payments) Board were about 60 % of those prevailing for private patients in 1987.

Broadly speaking, health authorities pay chemists' dispensing fees and the ingredient costs of prescribed drugs which are supplied free of charge to eligible patients. However, the rates of payment differ according to whether the patient has Category I status or is eligible under the scheme for chronically ill patients in Categories II or III. Category II or III patients who incur pharmaceutical expenses in excess of £28 in a month can obtain refunds from the Health Board for amounts over £28. A limited list of drugs can be prescribed for eligible patients: the exclusions mainly concern medicines which can be bought over the counter. Drug prices are controlled under an agreement with the pharmaceutical industry which links prices to those in the United Kingdom. This provides control of retail prices for private patients because there is a standard chemists' mark-up of 50 % on the wholesale price of the drug.

Public general, special and long-stay hospitals receive annual, global budgets for operating costs which are not covered by fee-paying patients. Typically, there are increments each year for inflation, changes in service provision and government policy on the rate of growth of expenditure. Voluntary general hospitals receive their budgets direct from the Department of Health. Other public hospitals receive their budgets from the health boards which themselves receive budgets from the Department. The process of setting budgets has been mainly "top down" in recent years: that is to say it has been determined mainly by the Department of Health. However, there is an element of negotiation, involving an assessment of hospitals' needs, prior to the setting of budgets. An element of bidding or negotiation is also involved in the allocation of supplementary funds made available for particular service initiatives, such as tackling waiting times. Detailed analysis of alternative methods of allocating resources, including the application of case-mix based approaches, has been undertaken and is continuing. There is no accounting for depreciation of the capital stock or for interest. Major capital expenditure is financed by capital grants and is under the direct control of the Department of Health.

Private hospitals rely heavily on payments by private patients who carry insurance with the VHI. The VHI tries to indemnify its members for the full cost of the specific hospital accommodation covered under its policies. It has used its monopsony power to bargain on fees with the private hospitals. On occasions, the Board has opposed the opening of new private hospitals and has tried to persuade private hospitals to make more use of day care and to reduce the average length of stay (Voluntary Health Insurance Board, 1987). It now pays public and private hospitals directly for services provided to its members.

- Charges for private and semi-private accommodation in public hospitals were increased substantially in real terms on several occasions;
- In 1987, £10 charges for first out-patient visits and for the first 10 days of in-patient care in public beds were introduced for Category II patients, and Category III patients became liable for the in-patient charges if they used a public bed. These charges were increased to £12.50 in 1991.
- In 1991, Category III was merged into Category II following a recommendation of the Commission on Health Funding.

GROWTH AND PERFORMANCE

The Irish health care system combines public and voluntary finance with public and private provision. The most important source of finance is general taxation, and central government has considerable discretion over the rate of growth of expenditure. That such discretion exists is illustrated by the rate of growth of health expenditure in the 1980s.

The economy went through a difficult period between 1980 and 1986; in four of the six years there was negative economic growth (OECD, 1989). The government responded by restraining sharply the growth of nominal public expenditure in the light of evidence which suggested that Ireland enjoyed comparatively high levels of public spending compared with countries with a similar standard of living. Public expenditure on health services actually fell in real terms in most of the years between 1980 and 1990 and by the end of this period it was down 8 % in real terms. This was accompanied by a 29 % decline in the number of acute hospital beds, a 29 % decline in average length of stay and a 13 % fall in admission rates.

According to OECD figures, there was a compensating rise in real private expenditure, by 55 %, and the private share of total spending rose from about 18 % to about 21 % in 1990. However, since private expenditure was much smaller than public expenditure, total real health expenditure still fell by 5 % over the period (Poullier, 1989). VHI premiums rose by 46 % in real terms between 1980 and 1988 (Commission on Health Funding, 1989). Although this rise was steep, it was lower than the real rise of 91 % in the average claim per person covered under private health insurance in the United Kingdom over the same period. Although this comparison is blurred by changes in membership and policies in both markets, it is tempting to conclude that the difference between the two figures reflects differences in the structure of the two insurance industries: regulated *monopsony* in Ireland and unregulated competition in Great Britain. The rise in premiums in Ireland was backed by an extraordinary surge of 350 % in tax relief over the period, taking it to about 28 % of VHI premiums on average (Commission on Health Funding, 1989, Table 4.3, deflated by figures in Poullier, 1989, Table 13).

The decline in total health expenditure showed up, also, as a fall in the share of GDP devoted to health, from 9.2 % in 1980 to 7.0 % in 1990. This is the sharpest fall (24 %) recorded among OECD countries over this period (see Chapter 10). To some extent, this can be seen as a reaction to the unusually rapid growth in the share of GDP devoted to health in the 1970s – from 5.6 % in 1970 to 9.2 % in 1980.

Health expenditure per head was US\$ 607 in 1987, 21 % higher than that in Spain, 81 % of that in the United Kingdom and 27 % of that in the United States. This was somewhat above the level which would be expected on the basis of a regression line linking GDP per capita to health expenditure per capita among major OECD countries (Schieber and Poullier, 1989).

According to OECD (1987), Schieber *et al.* (1991) and Table 10.2, Ireland had fairly typical rates per capita of prescriptions, acute hospital beds, and acute hospital admissions in the early 1980s. However, it had: an unusually low average length of in-patient stay in acute hospitals (7.4 days in 1986); one of the lowest levels of doctors per 1 000 (1.5 in 1987 compared with an average of 2.5 among the seven countries in this book) and a low level of physician contacts per capita (4.0 in 1980 judging by data obtained by Tussing, 1985). The low level of physician contacts is likely to have been mainly the result of the exposure of about 30 % of the population to all fees for GP care and another 30 % of the population to fees costing less than £ 100 in a year for an individual. Data on waiting times for hospital admission are not published routinely but a survey suggested that, in 1980, 7.8 % of all in-patients waited more than one month for admission to hospital and 1.6 % waited for more than one year (Tussing, 1985).

Turning to health status, in 1986, expectation of life at birth was 77 years for females and 71 years for males. Perinatal mortality was 0.99 % in 1989 (Table 10.3). The life expectancy rates are towards the bottom end of the range for OECD countries and the perinatal mortality figure towards the top end of the range. Although it is difficult to be precise about what exactly determines health status in any country, these figures are as likely to have resulted from relatively modest standard of living as from the performance of the health services. Perinatal

STRENGTHS AND WEAKNESSES IN THE SYSTEM

Publicly provided services

A distinctive mixture of public and private health care finance and provision has given the entire Irish population access to comprehensive services which are of high quality. Furthermore, the cost of supplying public services has been distributed across the entire population according to a taxation regime which is slightly progressive (Rottman and Reidy, 1988). The eligibility system entirely protects lower income groups from the hardship which would be associated with paying medical bills. All this has been achieved in a system in which expenditure on health, although it grew very rapidly in the 1970s, was cut back sharply during the 1980s.

However, there are persistent weaknesses in the Irish system, similar to those being experienced in other OECD countries. The period of rapid growth in expenditure (especially public expenditure) illustrated the tendency for health care systems which are financed largely by third parties to grow at unacceptably high rates unless checked. When a third party, such as the government, is paying for most health care, the patient has no incentive to economise. When, as in the Irish system before 1989, the GP, who acts as a gatekeeper, is paid by fee for service for public patients there are positive incentives for such doctors to induce demand.

The government was successful during the 1980s in countering the underlying tendencies in the system towards excessive public expenditure. It used methods such as control of GPs' fees (but not volume), tightening of global, block budgets in public hospitals, reducing beds, closing hospitals and greater reliance on salary payments for hospital specialists. At the end of the decade, there was a switch to capitation payments for the public patients of GPs. However, these measures were accompanied by a slight drop in public hospital admission rates, reports of lengthening waiting lists and strong protests about deteriorating access for public patients. These well-tried and effective systems for capping the expenditure of the providers also brought with them certain well-known, if potential, problems for incentives.

In the case of GPs, there is a risk that capitation payments will lead to underservice in place of overservice. This can be avoided if patients are in a position to identify poorly performing GPs and to change to another doctor. In other words, competition can be a safeguard against underservice. In the case of hospitals, tight block budgets are not designed to reward good performance. Competition between public hospitals has not yet been encouraged in Ireland. Hospital consultants who are salaried may be tempted to underserve their patients, especially when there is competition for their time from fee-paying patients. There is also the possibility that they may delegate work inappropriately to junior doctors. All this may generate failures in responsiveness to patients.

Some commentators have also been critical of the way in which the publicly provided health services are managed, and of weaknesses in management information. In particular, the Commission on Health Funding (1989) identified a confusion between political and executive functions; an inappropriate balance between national and local decision-making; insufficient involvement of clinicians in management; insufficient accountability; and insufficient integration of related services. The Commission also pointed to severe gaps in information, particularly on the costs of treatment, the need for services, and the outcome and quality of care.

Privately financed services

There are few causes for concern about the few health services where the patient pays the provider out-of-pocket for the full cost of care. The system has been designed so that it is mainly those who can afford to pay, and who choose not to have insurance, who are left in this situation. Their choices and those of their doctors are made in full awareness of the costs, although tax relief is available after a certain point on unreimbursed medical expenses. In practice, however, claims for such tax relief are few in number.

However, 30 % of the population is now covered by private health insurance with the VHI which has a monopoly of such insurance. There are three concerns here: risk selection, moral hazard, and tax relief.

- i) The VHI has used its monopoly power to establish community rating. This policy is popular because it favours those individuals with relatively poor health. However, it has almost certainly encouraged adverse selection of VHI policies by high-risk individuals (Nolan, 1991) and relative underconsumption of such policies by the healthy.
- ii) Most policies cover the full cost of a specified type of in-patient care and the cost of all GP and out-patient care after the first £100 for an individual and the first £170 for a family. This means that privately insured patients face no financial incentives to economise after the out-patient deductible is exceeded. Their doctors are invariably paid by fee for service which provides them with positive

Financing, eligibility and the public/private mix

The level of health funding could only be decided according to the available resources and the priority attached by society to different social objectives. It noted that allocative decisions in the health care field were often based on intuitive rather than objective criteria. On equity, it concluded essentially in favour of payment according to means, and access to services in relation to medical need.

Having explored various alternative funding mechanisms, it came down in favour of continuing reliance mainly on public funding, with private finance playing a supplementary role. The majority of the Commission's members favoured continuing dependence on general taxation but there was a minority report in favour of an earmarked health tax. The small, existing health contribution element of taxation should, however, be abolished.

Although the Commission favoured public *funding* of services, it declared that it made no presumption in favour of public *provision*. On the contrary, there should be flexibility for the public authorities in each area to turn to private providers (or to public providers in other areas) if this would be more cost-effective than direct provision. The Commission gave some cautious endorsement to the advantages of competition and competitive tendering among hospitals, nursing homes and domiciliary providers. However, it envisaged competitive tendering for the management of hospitals rather than changes in contracts which would affect the availability of facilities themselves.

On the three levels of eligibility for free public care, the Commission recommended, essentially, that there be no change to Categories I and II and abolition of Category III. This meant that the lowest income group would still be eligible for all health services, free of charge. The rest of the population would be entitled to core services free of charge, covering: all hospital care (subject to existing charges); a range of health services in the community, excluding GP services; and prescribed drugs costing more than £28 per month and for people suffering from certain chronic diseases. It also meant that patients would have to choose between public and private in-patient care. They would not be able to combine a public bed with a private consultant's services.

The Commission rejected any significant increase in user charges for public services, while accepting the principle of modest direct contributions. It envisaged continuation of private care and private health insurance. Consequential inequities in access would be acceptable provided adequate standards of public care were preserved. While it expressed support for community rating, it hesitated over the future of the VHI monopoly, partly because of doubts about its efficiency, but mainly because of uncertainty as to whether it could continue after the completion of the internal market of the European Community.

The Commission recommended the phasing out of tax relief for private health insurance on the grounds that this was inequitable and poorly targeted on need. Its recommendation about universal access to core services free of charge further undermined the case for tax relief.

Administration, management and management information

The kernel of the Commission's conclusions was that the solution to the financing question did not lie primarily in the system of funding, but rather in the way that services were planned, organised and delivered. In this connection, the Commission made a number of recommendations:

- The Minister's policy and management roles should be separated and the latter should be transferred to an executive authority with a chief executive and area general managers at the level of the existing health boards;
- The health boards should be transformed into health councils charged with playing a local policy role, representing consumer interests and monitoring the quality of care;
- There should be clarification of the role of voluntary hospitals and agencies and they should be funded for an agreed level and type of service;
- There should be a performance audit unit.

The Commission also laid stress on the need for better management information and evaluation. A number of recommendations were made for health population profiles, better measurement of effectiveness, and better measurement of costs. There should be more cost-benefit analysis and more health technology assessment. The Health Executive should acquire the services of qualified and experienced clinicians to assist in performance evaluation. Epidemiological and health services research should be strengthened.

likely to reduce some of the ambiguities and tensions on the boundaries between public and private health care. They are also likely to contribute to better management, both in hospitals and in ambulatory care.

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Appendix 6

Members of the Joint Committee

Deputies:	Michael Ahern (FF)	Senators:	Dermot Fitzpatrick (FF)
	Paul Bradford (FG)		Camillus Glynn (FF)
	Paul Connaughton (FG)		Mary Jackman (FG)
	John Dennehy (FF)		Pat Moylan (FF)
	Beverley Cooper-Flynn (FF)		Kathleen O'Meara (Lab) ¹
	John Gormley (GP)		
	Cecilia Keaveney (FF)		
	Brendan Kenneally (FF)		
	Liz McManus (Lab) ²		
	Gay Mitchell(FG) ³		
	Dan Neville (FG)		
	Batt O'Keeffe (FF)		
	Michael Ring(FG) ⁴		
	G.V. Wright (FF)		

¹ Senator Kathleen O'Meara was appointed in place of Senator Pat Gallagher on 4 November 1999

² Deputy Liz McManus was appointed in place of Deputy Róisín Shortall on 4 November 1999

³ Deputy Gay Mitchell was appointed in place of Deputy Alan Shatter on 29 June 2000

⁴ Deputy Michael Ring was appointed in place of Deputy Deirdre Clune on 29 June 2000

Appendix 7

Orders of Reference of the Joint Committee

Provided that the Joint Committee shall not, at any time, consider any matter relating to such a body which is, which has been, or which is, at that time, proposed to be considered by the Committee of Public Accounts pursuant to the Orders of Reference of that Committee and/or the Comptroller and Auditor General (Amendment) Act, 1993.

Provided further that the Joint Committee shall refrain from inquiring into in public session, or publishing confidential information regarding, any such matter if so requested either by the body or by the Minister in charge of that Department; and

- (v) such other matters as may be jointly referred to it from time to time by both Houses of the Oireachtas,

and shall report thereon to both Houses of the Oireachtas.

- (b) The quorum of the Joint Committee shall be 5, of whom at least 1 shall be a member of Dáil Éireann and 1 a member of Seanad Éireann.
- (c) The Joint Committee shall have the powers defined in Standing Order 78A(1) to (9) inclusive. *

- (3) The Chairman of the Joint Committee, who shall be a member of Dáil Éireann, shall also be Chairman of the Select Committee.

* The following motion was passed by Dáil Éireann on 12 December 2000:

"That the Joint Committee on Health and Children shall have the power to send for persons, papers and records as defined in Standing Order 79. This Order shall cease to have effect on 30th June, 2001."

62A(1) to (9) inclusive.*

(2) The Chairman of the Joint Committee who shall be a member of Dáil Éireann.

* The following motion was passed by Seanad Éireann on 13 December 2000:

"That the Joint Committee on Health and Children shall have the power to send for persons, papers and records as defined in Standing Order 68. This Order shall cease to have effect on 30th June, 2001."

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Appendix 8

Proceedings of the Joint Committee

AN COMHCHOISTE UM SHLÁINTE AGUS LEANAÍ THE JOINT COMMITTEE ON HEALTH AND CHILDREN

Imeachtaí An Chomhchoiste

Proceedings of the Joint Committee

Dé Céadaoin, 24 Eanáir 2001

1. The Joint Committee met at 11 a.m. in Room G5, Kildare House.

2. MEMBERS PRESENT.

The following members were present:

Deputies Batt O'Keeffe (*in the chair*), Michael Ahern, Paul Bradford, John Gormley, Cecilia Keaveney, Billy Kelleher*, Liz McManus, Dan Neville, Michael Ring and G.V. Wright.

Senators Camillus Glynn and Pat Moylan.

* in substitution for Deputy John Dennehy

3. DRAFT REPORT

Deputy Liz McManus brought forward a report entitled "A Comparative Analysis of Waiting Lists for Acute Hospital Treatment in EU Countries". The Report was read and amended. The Report, as amended, was agreed.

Ordered: To report accordingly.

4. ADJOURNMENT

The Committee adjourned at 11.24 a.m.

Seanad Éireann

19 November 1997(** 30th April, 1998),

Ordered

- (1) (a) That a Select Committee consisting of 5 members of Seanad Éireann shall be appointed to be joined with a Select Committee of Dáil Éireann to form the Joint Committee on Health and Children to consider—

- (i) such public affairs administered by the Department of Health and Children as it may select, including bodies under the aegis of that Department in respect of Government policy,
- (ii) such matters of policy for which the Minister in charge of that Department is officially responsible as it may select,
- (iii) the strategy statement laid before each House of the Oireachtas by the Minister in charge of that Department pursuant to section 5 (2) of the Public Service Management Act, 1997, and shall be authorised for the purposes of section 10 of that Act, and
- (iv) such Annual Reports or Annual Reports and Accounts, required by law and laid before either or both Houses of the Oireachtas, of bodies under the aegis of the Department(s) specified in paragraph 1(a)(i), and the overall operational results, statements of strategy and corporate plans of these bodies, as it may select.

Provided that the Joint Committee shall not, at any time, consider any matter relating to such a body which is, which has been, or which is, at that time, proposed to be considered by the Committee of Public Accounts pursuant to the Orders of Reference of that Committee and/or the Comptroller and Auditor General (Amendment) Act, 1993.

Provided further that the Joint Committee shall refrain from inquiring into in public session, or publishing confidential information regarding, any such matter if so requested either by the body or by the Minister in charge of that Department; and

- (v) such other matters as may be jointly referred to it from time to time by both Houses of the Oireachtas,

and shall report thereon to both Houses of the Oireachtas.

- (b) The quorum of the Joint Committee shall be 5, of whom at least 1 shall be a member of Dáil Éireann and 1 a member of Seanad Éireann.
- (c) The Joint Committee shall have the powers defined in Standing Order

Joint Committee on Health and Children

ORDERS OF REFERENCE

Dáil Éireann

13th November, 1997, (28th April, 1998),**

Ordered:

- (1) (a) That a Select Committee, which shall be called the Select Committee on Health and Children, consisting of 14 members of Dáil Éireann (of whom 4 shall constitute a quorum), be appointed to consider such—
 - (i) Bills the statute law in respect of which is dealt with by the Department of Health and Children, and
 - (ii) Estimates for Public Services within the aegis of that Department,as shall be referred to it by Dáil Éireann from time to time.
- (b) For the purpose of its consideration of Bills under paragraph (1)(a)(i), the Select Committee shall have the powers defined in Standing Order 78A(1), (2) and (3).
- (c) For the avoidance of doubt, by virtue of his or her *ex officio* membership of the Select Committee in accordance with Standing Order 84(1), the Minister for Health and Children (or a Minister or Minister of State nominated in his or her stead) shall be entitled to vote.
- (2) (a) The Select Committee shall be joined with a Select Committee to be appointed by Seanad Éireann to form the Joint Committee on Health and Children to consider—
 - (i) such public affairs administered by the Department of Health and Children as it may select, including bodies under the aegis of that Department in respect of Government policy,
 - (ii) such matters of policy for which the Minister in charge of that Department is officially responsible as it may select,
 - (iii) the strategy statement laid before each House of the Oireachtas by the Minister in charge of that Department pursuant to section 5(2) of the Public Service Management Act, 1997, and shall be authorised for the purposes of section 10 of that Act, and
 - ** (iv) such Annual Reports or Annual Reports and Accounts, required by law and laid before either or both Houses of the Oireachtas, of bodies under the aegis of the Department(s) specified in paragraph 2(a)(i), and the overall operational results, statements of strategy and corporate plans of these bodies, as it may select.

The services

The Commission recommended that all public hospitals should be given clear objectives and should be funded according to an agreed level of services based on activities and unit costs classified by diagnosis-related groups (DRG). An important step in this direction was the completion of a major study developing DRGs for acute in-patients in Ireland and the piloting of a DRG costing procedure in three acute hospitals (Wiley and Fetter, 1990).

There should be common waiting lists for public and private patients in public hospitals and publication of maximum waiting times. In addition, there should be monitoring of the public time commitment of consultants.

The linking of drug prices to those in the United Kingdom should be terminated in favour of a limited list of drugs for which prices would be negotiated directly with the drug companies.

Measures should be taken to strengthen prevention and health promotion.

There should be better evaluation of alternatives for long-term care and better co-ordination of the existing services.

PROPOSALS EVALUATED

There are parallels between the Commission's proposals and the current reforms to the health care system in the United Kingdom – for example, tighter management in the public sector, competition among providers, better representation for consumers and improved management information. The Commission, however, was cautious in its endorsement of competition among providers. The proposals for making free access to core services available to all Irish citizens, reducing the tiers of eligibility to two and phasing out tax relief, seem well judged when viewed against the objective of improving the balance between public and private patients, particularly in public hospitals.

The Commission was ambivalent in its support for the VHI, although it favoured continuation of community rating. It may have underestimated the advantages which a regulated, monopsony insurer has over competitive insurers in holding down the rate of increase of private sector costs, as well as insurance premiums. Given the competition policy of the European Community, however, it is not clear that the option of allowing the monopsony to continue is available.

The Commission's report was followed in 1990 by the report of the Stationery Office. The Review Body's main recommendations on the remuneration and terms and conditions of employment of consultant medical staff included:

- The introduction of new categories of consultant posts and mechanisms which would entail higher remuneration for greater commitment by consultants to the public sector;
- Clearer definitions of the responsibilities of consultants and of the hospitals in which they worked;
- More involvement of clinicians in management;
- The introduction of contractual arrangements to support the introduction of medical audit systems, and
- Significant increases in consultants' remuneration.

WAY FORWARD

The government's response to the findings of the Commission on Health Funding was to welcome the overall thrust of the report, while making no immediate decisions on either structural reform or funding arrangements. During 1991, however, legislation was introduced to merge eligibility Category III into Category II, resulting in a two-tier eligibility system. The government also accepted the recommendations of the Review Body on the remuneration and terms and conditions of employment of consultant medical staff as a basis for further discussions with the medical profession. In 1991, a national agreement between all the social partners (government, employers, trade unions, farmers) included a commitment to the establishment of a Performance Audit Unit in Department of House (Stationery Office, 1991a). In 1990, the Minister for Health announced an "action plan" for the health services with the aim of improving their efficiency and effectiveness. The Dublin Hospital Initiative Group which participated in this strategy reported in 1991, and recommended the establishment of a Regional Hospital Authority in Dublin, outside of the Health Board Structure. This, and other proposals, for structural reform are currently being considered (Stationery Office, 1991b). These reforms are

incentives to induce demand. It is not surprising, therefore, that VHI premiums rose by 46 % in real terms between 1980 and 1988.

In the late 1980s, the government constrained the rate of increase of premiums of the VHI. This, combined with a policy of unrestrained, cost-based reimbursement for hospital bills, led to a financial crisis in 1989 because claims grew faster than premiums. Measures had to be taken to reduce members' entitlements, to negotiate global financial agreements with private hospitals and to agree tighter definitions within fee schedules with the medical profession.

- iii) Tax relief accounted for about 28 % of the cost of VHI premiums in 1987, having risen by 350 % in real terms since 1980. There are a number of problems with granting tax relief for private health insurance, particularly at the marginal rate of income tax. It is inequitable because it favours those on higher incomes more than those on lower incomes. It is inefficient because it lowers the price of insurance, thereby encouraging individuals to take out cover they would not otherwise buy. This reduces awareness of the cost of premium rises and, given the moral hazard associated with health insurance, is akin to pouring petrol on a fire. Compared with direct public expenditure on health services, tax relief is poorly targeted on medical need. It can be used to pay for treatments and hotel luxuries, which would not be provided under a public scheme, and for priority access to doctors by private patients.

Frontiers between the public and the private sectors

Many of the weaknesses in the way the system works may be seen most clearly as strains and stresses on the frontiers between the public and private health sectors, particularly in public hospitals. The Commission on Health Funding received ample testimony that private patients in public hospitals enjoyed shorter waiting times and more personal attention from consultants than public patients. It also heard suggestions that some consultants were not fulfilling the terms of their public contracts. There have been reports (Lancet, 1989) that the cuts in public expenditure and the growth of private practice have led to lengthening waiting lists and premature discharge of public patients, not forgetting the sharp drop in hospital admissions in recent years.

There are sound economic and policy reasons for allowing private care in public hospitals. It can help to give public as well as private patients access to the best doctors and it can provide a welcome source of revenue for the public sector. However, there are likely to be equity difficulties within the public sector if public and private care are not kept financially separate. Two important principles are that there should be a clear financial separation between public and private transactions and that the private patient should pay the full cost of the service that he or she receives. Otherwise, there is a danger that public funds and resources will be diverted according to private preferences and ability to pay.

In Ireland, the main problem seems to be the extent to which there are subsidies to private care. The extent of which was noted in relation to private insurance. Furthermore, there was an anomaly in that Category III patients were allowed to use a public bed while enjoying the private services of a consultant. This is no longer the case following the 1991 legislation. In addition, there were also subsidies built into the pricing of private and semi-private beds in public hospitals, although these seem to have been virtually phased out by sharp increases in private bed charges in the 1980s.

COMMISSION ON HEALTH FUNDING

The sharp cuts in real public expenditure on health were largely responsible for the financing and organisation of health care becoming politically controversial during the 1980s. The government responded by appointing the Commission on Health Funding in June 1987 with terms of reference, "To examine the financing of the health services and to make recommendations on the extent and sources of the future funding required to provide an equitable, comprehensive and cost-effective public health service and on any changes in administration which seem desirable for that purpose".

The Commission reported in September 1989 with an evaluation of health services which, in many ways, – and despite some fairly radical proposals for reform – represented a vote of confidence in the health care system. The Commission's main conclusions and recommendations are considered hereafter.

mortality has declined steadily in the past three decades and it continued to decline between 1980 and 1989, despite only modest economic growth through 1987 and real cuts in health expenditure.

Turning to the question of access to acute health care, the combination of eligibility categories and the availability of private health insurance means that different groups of patients face different financial incentives (see Tables 6.1 and 6.2). And depending on whether the patients are public or private, the providers are also presented with different incentives. Occasional household surveys have explored the effects of consumer and provider incentives on the way in which health care is used.

Tussing (1985) carried out a household survey in 1980 which included questions on medical care utilisation, age, sex, occupation, eligibility category and insurance cover, but not health status. He used regression analysis to explore the determinants of utilisation. His tests of three hypotheses are worth reporting:

Hypothesis I: That since Category I patients received free care from GPs paid by fee for service, they would have more visits, and more return visits for any initial visit, than Category II or III patients who were obliged to pay for their care. This was borne out strongly both by the crude data, which showed that Category I patients had 2.5 times as many visits as Category II and Category III patients, and by regression analysis which controlled for some of the potentially confounding variables. It was likely that the poor health status of Category I patients played a part in this result. However, comparisons between Irish and British GP consultation rates suggested that whereas the lower occupational groups had higher consultation rates than the higher occupational groups in both countries, the lower occupational groups had *relatively* much higher rates in Ireland. Since all British groups enjoy free GP care and British GPs are paid mainly by capitation and salary, this suggested that the restriction of free care to the lower occupational groups in Ireland, combined with fee-for-service payment of GPs, played a part in raising consultation rates by Category I patients independently of health status.

Hypothesis II: That fee-for-service payment of GPs for Category I patients would encourage doctors to induce demand by asking such patients to make return visits. More specifically, return visits would be higher when doctors' incomes came under pressure, such as when the doctor/population ratio was higher, other things being equal. The analysis established that return visits were, indeed, higher the greater the doctor/population ratio. Since Tussing completed his analysis, further evidence has emerged suggestive of GP-induced demand associated with pressure on their incomes. Visiting rates for Category I patients rose by 12 %, from 5.8 per capita in 1980 to 6.5 per capita in 1987 at a time when rises in fees for Category I patients were declining by about 10 % in real terms. There was no evidence of rising consultation rates for other categories of patient judging by the available household surveys (Commission on Health Funding, 1989, page 209). Such divergent trends are reminiscent of comparisons between physician payment systems in Canada and the United States (Barer, Evans and Labelle, 1988).

Hypothesis III: That Category II and III patients with VHI cover would make more visits to GPs than patients without such cover. This was borne out by the analysis but it remained unclear whether the effect was due to health status and to adverse selection rather than to moral hazard.

Nolan (1991) was able to explore some of these relationships more thoroughly using a 1987 household survey which included data on health status and income in addition to data on the household characteristics included in Tussing's survey. The health status variable was a simple dichotomy between those suffering from a serious illness or disability and those who were not. The survey took place at a time when GPs were still being paid by fee for service for Category I patients. Nolan found crude differences in visiting rates between Category I patients and other patients, similar to those found by Tussing. He showed that, other things being equal, health status was indeed an important determinant of these differences. However, whereas the inclusion of the health status variable in regression analysis similar to that carried out by Tussing reduced the explanatory power of Category I eligibility over the total number of GP visits in the year, it by no means removed it altogether.

Although the crudeness of the health status variable could have accounted for these results, the suggestion remains that patient and doctor incentives play an independent part in determining utilisation of GP services. Nolan also showed that health insurance cover was associated positively and significantly with visits to GPs and with hospital utilisation and length of stay, after allowing for other explanatory variables, including health status. However, given the simple nature of the health status variable used, the effect of health insurance might have been over-estimated.

Further evidence on the effect of provider incentives on activity rates was forthcoming in the wake of the switch, in March 1989, from fee-for-service to capitation payments for GPs providing care to Category I patients. Early reports suggested that consultation rates fell by about 20 % in the first year.

Before 1991, only Category I and II patients were entitled to free or heavily subsidised care as out-patients or in-patients by medical specialists. Since Category III was merged with Category II in 1991, this has applied to all residents. About 40 % of specialists are consultants who can take full responsibility for patients and are allowed to have private patients. The rest are junior doctors who work mainly in public hospitals. About 90 % of consultants have appointments in public hospitals and the vast majority of these have "full-time" contracts. A new contract was agreed with the hospital consultants in 1991, under which consultants could commit to different categories of hospital appointments. These appointments varied in salary levels and the facility to work in private practice, in association with the service commitment in public hospital. Consultants are paid by salary for their work with public patients, as are junior doctors. They are paid by fee for service for private patients, including, until 1991, all those with Category III eligibility.

GOVERNMENT PLANNING AND REGULATION

The public sector plays a dominant role in financing and, to a lesser extent, in providing and managing health care. About four-fifths of total health expenditure in the late 1980s was public, and another 9 % passed through the VHI, which, in some respects, acts as a public body. On the providing side, 74 % of beds are in public hospitals and most of the community health services are provided by the eight health boards.

This has enabled central government to exert considerable control, directly or indirectly, over the rate of growth of health expenditure and over the shape and pattern of health services. Ireland is one of those few OECD countries which has succeeded not just in reducing the rate of growth of public expenditure on health but in making absolute cuts in real expenditure during the 1980s. Relatively small areas of the health sector – mainly private GP services – are left to be shaped by market forces.

In addition to the various public financing and management mechanisms discussed above, the government exerts some control over numbers of doctors through limits applied by the education authorities on the places available for medical students, and through a committee (*Comhairle na nOspideal*) which regulates the number and type of consultant medical staff in hospitals and advises the Minister of Health on the organisation and operation of hospital services. Although central government makes few attempts to influence the clinical activities of doctors, the GMS (Payments) Board scrutinises the activity and prescribing of GPs who provide services for medical card holders, and investigates those claims which are significantly higher than average.

RECENT REFORMS

In 1989, the government introduced capitation payments in place of fee-for-service payments for the care provided to medical card holders (Category I patients) by most general practitioners. This was the most important reform of the past decade prior to the Report of the Commission on Health Funding. It was introduced because of concerns that the fee-for-service method of paying GPs (the level of fee was about 60 % of that for private patients) encouraged over-visiting, over-prescribing and the medicalisation of minor illnesses (Commission on Health Funding, 1989). Indeed, there was some evidence of higher consultation rates, especially return visits, by medical card holders, and of higher prescribing levels for these patients.

The new method of paying GPs introduces capitation payments weighted by the age of the patient (in five bands), the sex of the patient, and the distance between the patient's home and the doctor's practice (in 20 categories depending on the five age bands and four distance bands). In addition, there are extra out-of-hours payments and special payments for a few items of service. The scheme allows for superannuation and various forms of leave payments (for details, see Commission on Health Funding, 1989, Appendix 11A).

A series of other reforms were introduced since the end of the 1970s:

- In 1979, Category III patients were granted eligibility for free care in public beds but they remained responsible for consultants' fees;
- Between 1981 and 1983, a new consultants' contract was negotiated, placing all consultants on salary for their services to public patients. Previously, consultants in voluntary hospitals had been paid by a mixture of sessional payments for out-patients and per-patient-day payments for in-patients;
- In 1982, about 900 items, mainly over the counter medicines, were removed from the list of drugs which could be prescribed under the public scheme;
- In 1983, manufacturers' drug prices were tied to those in the United Kingdom;
- In 1983 and in 1984, the threshold for patients to claim back pharmaceutical expenditure under the drugs subsidy scheme was raised;

Table 6.1. Eligibility for free health services and health insurance cover, 1987

	Without Insurance (% population)	With Insurance	Total
Category I	36	1	37
Category II	32	16	48
Category III	4	11	15
Total	72	28	100

Source: Estimated from Commission on Health Funding (1989), and Nolan, 1991.

Table 6.2. Access to health care: eligibility and insurance coverage, 1989

	Eligibility for free (public) health services	Examples of additional cover with health insurance policies from the VHI
Category I:	<ol style="list-style-type: none"> 1. Public in-patient care 2. Specialist doctor services 3. Maternity and infant welfare services 4. All prescribed medicines 5. Dental, ophthalmic and aural services 6. General practitioner care 7. All other publicly funded health services 	E.g. <i>add</i> semi-private accommodation in public hospitals, plus treatment in private hospitals and private specialist doctor's fees.
Category II:	<ol style="list-style-type: none"> 1. Public in-patient care subject to a £10 charge per day for the first 10 days in any one year 2. Specialist doctor services subject to a £10 charge for the first visit for any one condition 3. Maternity and infant welfare services 4. Prescribed medicines after the first £28 per month, or in the case of certain chronic illnesses 5. All other publicly funded health services (excluding 5 and 6 in Category I above) 	E.g. <i>add</i> private accommodation in public hospitals, plus treatment in private hospitals, private specialist doctor's fees and GP and out-patient expenses, excluding the first £170 per year for a family (£100 for an individual) subject to a £1 200 ceiling.
Category III:	<ol style="list-style-type: none"> 1. Public in-patient care subject to a £10 charge per day for the first 10 days in any one year 4. Prescribed medicines after the first £28 per month, or in case of certain chronic illnesses 5. All other publicly funded health services (excluding 2, 3, 5 and 6 under Category I above) 	E.g. <i>add</i> private accommodation in public hospitals plus treatment and medical extras in private hospitals, private specialist doctors' fees, and GP and out-patient expenses, excluding the first £170 per year for a family (£100 for an individual) subject to a £1 400 ceiling.

Note: Category III was merged into Category II in 1991.

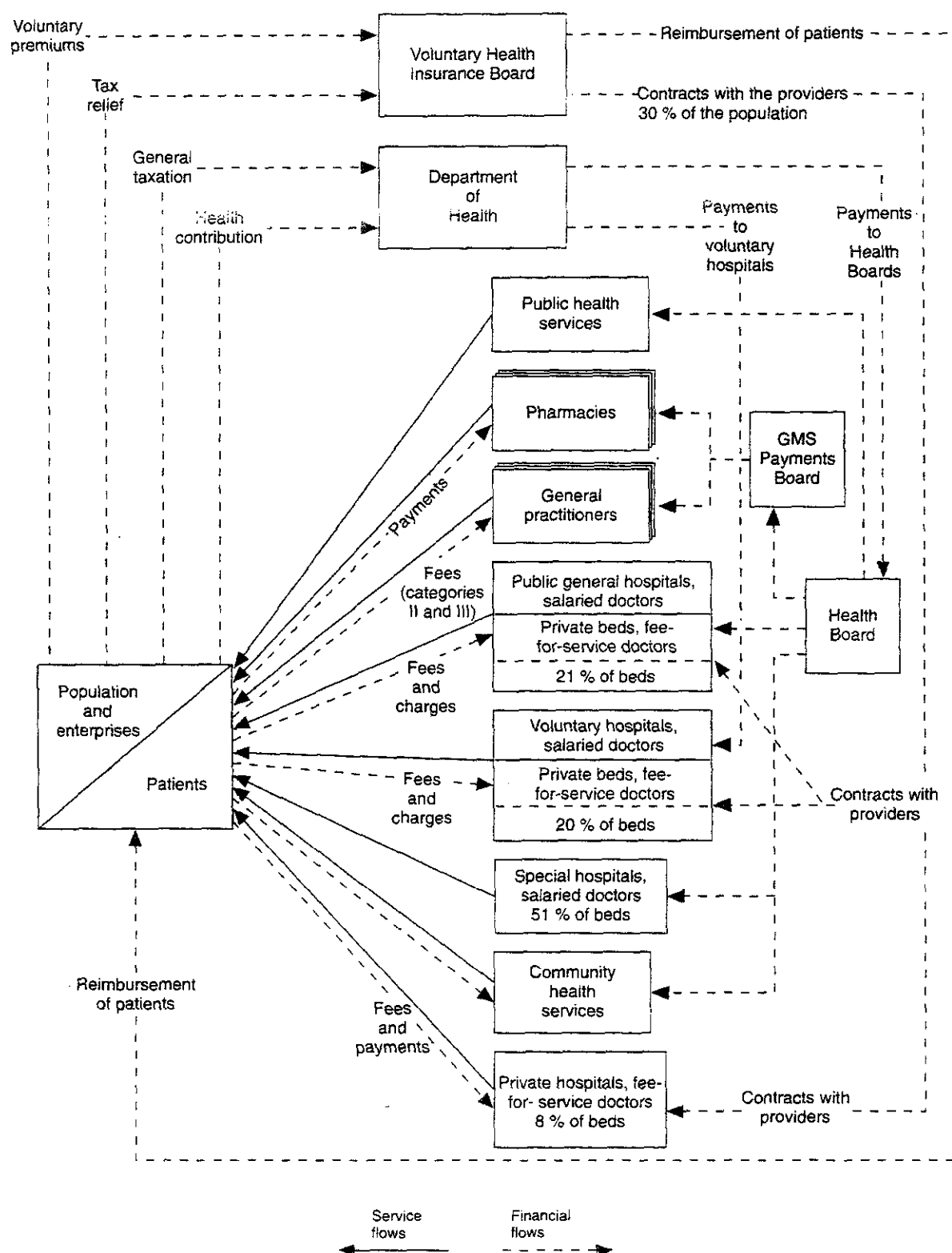
varied between some of the groups. Table 6.1 provides estimates of the numbers in each eligibility category and of those with or without insurance cover.

RELATIONSHIP BETWEEN THE POPULATION AND THIRD-PARTY PAYERS

Ireland has fewer third-party health service funders than most OECD countries. There are only two of any importance: the Department of Health (or central government) and the Voluntary Health Insurance Board (VHI). In 1987, central government accounted for about 78 % of total health expenditure, the VHI for about 9 %, leaving about 13 % for direct payments (Stationery Office, 1989, Table 4.1).

Central government expenditure is raised mainly from general taxation; there is also a specific health contribution levied at the rate of 1.25 % on the income of non-medical card holders, up to a ceiling of £15 500 in the 1988/89 tax year. However, this accounts for only about 5 % of total health expenditure. The Department of Finance has the capacity to exert tight central control over the level of public expenditure on health in each budget period.

Chart 6.1 The system of health care in Ireland



VARIETIES OF GOVERNMENT REGULATION

We have not yet considered variations in government regulation of health care systems. From the point of view of this study, the most important distinction seems to be that between:

- Government measures which promote markets and self-regulation; and
- Government intervention of the detailed command-and-control type.

Measures to promote self-regulation can be described broadly as “pro-market” or “pro-competitive”. They are aimed generally at: local autonomy of consumers, insurers and providers, an appropriate balance of power between them and appropriate incentives for them to consume, finance and provide health care in a cost-effective fashion. Government intervention of the command-and-control type is generally aimed at supplanting or overriding market forces and institutions. It may include: specifying the coverage of insurance policies, regulating membership and premiums, controlling the quantity, quality and prices of services, fixing wages, and planning capacity. In practice, all the systems in this study – with the probable exception of that of Eastern Germany, prior to reunification – contain a mixture of both types of regulation. To some extent, the precise mix will depend upon the ideology of past and present governments. But it will also depend upon the dominant models of finance and delivery.

We have already seen that a free market for health care cannot easily be left to regulate itself. Because of the asymmetry of knowledge between patients and health professionals, all seven governments have granted doctors (and other health professionals) collective monopolies of supply and self-regulation in exchange for the adoption and maintenance of professional standards of behaviour. If these monopolies are not to be abused, a measure of pro-competitive regulation may be required. Private health insurance tends to suffer from risk selection and moral hazard. Because moral hazard can be countered in the voluntary contract and integrated models, governments may introduce pro-competitive policies to encourage the development of these models, especially if these might benefit public programmes suffering from problems of cost-containment.

Alternatively, governments may intervene in private health care markets with detailed regulations of the command-and-control type. In Ireland, for example, voluntary health insurance is supplied by a single, quasi-government insurer which imposes community rating. In the Netherlands, private insurers have been mandated to provide basic insurance at set premiums for certain high-risk individuals who are not eligible for public insurance. In the United Kingdom, however, where private health insurance plays a strictly supplementary role, there is relatively little regulation of the private insurance market.

Where governments have introduced public financing, they have generally gained control of the corresponding health insurance function – more so in the case of centrally financed schemes than in the case of quasi-independent sickness funds. Despite this, the public reimbursement model, at least in its pure form, is likely to suffer from problems of cost-containment because of its lack of influence over providers. This may lead to detailed government regulation by the backdoor of, say, the capacity of providers and the prices which they are allowed to charge.

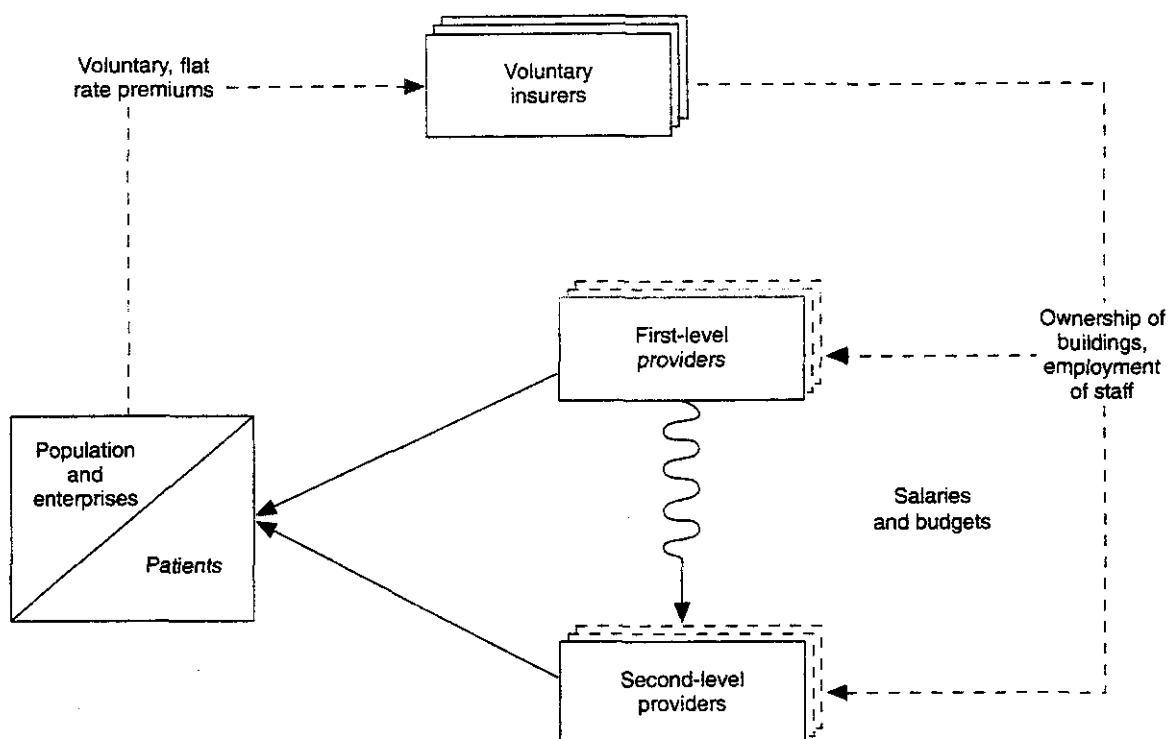
The public contract model is less vulnerable to cost-containment problems and is much more amenable to local self-regulation, especially if the insurers are allowed to exert monopsony power, if money follows the patient, and if competition is encouraged between providers. Germany provides an example of this. The integrated model brings with it government control over both insurers and providers – typically through line management. Paradoxically, this model can coexist with higher levels of clinical autonomy than other models (Schulz and Harrison, 1986) and considerable delegation to local management bodies. This is because of its ability to secure a firm framework of expenditure control.

SUMMARY OF HYPOTHESES ABOUT THE PERFORMANCE OF SUB-SYSTEMS

In this chapter, we have made preliminary assessments of the sub-systems of finance, payment and regulation of health care, in the light of the policy objectives which we discussed in the previous chapter. This provides us with some hypotheses about the performance of the sub-systems, to be kept in mind when we examine whole systems and their reforms in Chapters 3 to 9.

Three main pointers emerge: all the voluntary models have difficulties meeting adequacy and distributional objectives; both types of reimbursement model have difficulties achieving the cost-containment objective; and there are question marks against the ability of the public integrated model to achieve micro-economic objectives. The public contract model has been granted the highest positive score among the seven sub-systems. Question marks are placed against the health outcome objective for all the models. This is because there is scant evidence

Chart 2.6 Voluntary insurance with integration between insurers and providers



The public integrated model

The public version of the model discussed above was, however, widely adopted in compulsory systems. Chart 2.7 shows this version with: services supplied to patients in kind; third-party payments organised by public funding bodies, usually central or local government; financing by compulsory income-related contributions, often via general taxation; and payments to providers by salary and prospective budgets. Here, government is both the principal insurer and the major provider – as in the U.S. Department of Veterans Affairs. Variations on the model are possible, including financing by social insurance contributions and a greater or lesser degree of clinical autonomy. In general, consumers have no choice of insurer within the public scheme. In the pure version of the model, their choice of provider is also likely to be limited. However, even when consumer choice of provider is encouraged, it is likely to be financially ineffective (see below).

The public version of the integrated model is distinguished by lacking both consumer choice of insurer and choice (or effective choice) of provider. Compared with the voluntary version of the integrated model, the incentives for under-service are not countered by the need for the third parties to retain the custom of the insured. Compared with the public contract model, consumer choice of provider and choice of hospital by the primary care doctor – although these may exist – are ineffective. Money does not follow the patient when providers are paid by salaries and global budgets. This means that the incentives for providers are perverse (Enthoven, 1985). Efficient providers are rewarded by more work but not by increased resources. Inefficient providers are rewarded by a quiet life and idle resources. Queues for services are commonplace, and patients tend to become grateful supplicants rather than empowered consumers. In addition, it lacks incentives for providers to minimise unit costs. For example, underspending by hospitals in one year is often met by grant reductions in the following year. Macro-economic efficiency becomes the responsibility of government, and because of the integrated nature of the model it is relatively easy for the government to control total health expenditure at the level it desires. The integrated model is probably capable of achieving further administrative economies compared with the contract

negotiate economical but high-quality care on behalf of consumers. If hospital care is offered under this model, primary care physicians are likely to act as gatekeepers.

Voluntary health insurance arrangements have a better potential for achieving macro- and micro-economic efficiency than "conventional" insurance. This is because of the countervailing power exercised by the insurers and the gatekeeper role played by the primary care physicians. In the hands of doctors, with fee-for-service payment, this potential may not be fully realised (Enthoven, 1988). Historical research in the United Kingdom (Green, 1985) as well as contemporary research in the United States (Enthoven, 1988), however, suggests that in the hands of consumers or independent insurers, and with capitation payments to doctors, this model can yield major savings without loss of quality. There are likely to be savings in administration costs over conventional insurance. The main disadvantage is the limited capacity to achieve equity or solidarity.

Although friendly societies played an important historical role in Europe, their markets tended to be confined to employed workers and their dependants. This left significant sections of the population without insurance. Friendly societies were also unpopular with organised medicine because of: the local market power which they gave to collectives of consumers; the threat of lay control which this posed for doctors; and their potential for eroding the size of the fee-for-service sector. They were swept aside in favour of: compulsory sickness funds; fee-for-service remuneration or central negotiation of capitation payments; and "free choice of doctor" when national schemes were introduced (Green, 1985; Abel-Smith, 1988). Abel Smith has suggested that the abolition of competition which resulted was the price that governments often found themselves paying in order to secure universal health insurance. Nevertheless, organisations of the Individual Practice Association and prepaid group practice type remain common in the Spanish private sector.

The public contract model

The basic design of the contract model was frequently imported into compulsory health insurance schemes in Europe. Chart 2.5 shows a public contract model with: services supplied to eligible consumers in kind; non-competing sickness funds or funding bodies; compulsory, income-related contributions; and direct fee-for-service or capitation payments by the sickness funds to independent providers. Again, this model comes in a number of versions. The source of funds may be general taxation rather than contributions. Instead of sickness funds, the third parties may be central or local government, or even first-level doctors in the case of second-level providers. And the providers, especially if they are hospitals, may be public bodies. The main features of this model are that the third parties are public and that they have contractual relations with the providers – in other words, there is separation between the funding bodies and providers. It is also usual for methods of paying providers to be, at least in part, work-related.

It is (or, in some cases, was) common in European social insurance systems for providers to have won the right to contract with any sickness fund, under the banner of "free choice of doctor". This can widen consumer choice compared with the voluntary model, but at the cost of converting local sickness funds into passive payment offices. This prevents the funds from exploiting their monopsony power locally. As a result, negotiation over fees and charges usually takes place between regional or national associations of sickness funds (or central government bodies) and providers under bilateral monopoly. When this is combined with choice of provider by patients it leads to consumer-led competition over the quantity and quality of services, but not over price.

The public contract model shares many of the characteristics of the voluntary version. It is capable of preserving freedom of choice of provider for consumers, although this depends on the scope of the contracts negotiated by the third parties. It does not usually offer freedom of choice of insurer. Macro-economic efficiency tends to become the responsibility of government. Considerable potential exists for achieving micro-economic efficiency by a combination of consumer-led competition over quality, and the development of suitable incentives and regulations in the contracts between the insurers and the providers. Both are subject to information constraints, however. If payment is by capitation there are likely to be economies compared with the reimbursement model. Administration costs are also likely to be lower in comparison with the reimbursement model. Because the model involves compulsion it can be designed to provide universal coverage and the desired level of equity.

In various versions, this is now the dominant model for primary care doctors in Germany, Ireland, the Netherlands, and the United Kingdom, and for hospitals in Belgium, the Netherlands, Germany and the United Kingdom. The contract model also plays a part in payments to primary care doctors in Belgium and France. It is, moreover, a model which is continuing to be developed and around which many of the reforms discussed in Chapters 3 to 9 are centred.

First, when the consumer is protected by this and other types of insurance, he or she has no incentive to restrain his or her demand (moral hazard) and knowing this, and with fee-for-service payments, the providers have positive incentives to induce demand. Competition may serve to stimulate the volume and quality of services and to raise, rather than to reduce, prices. For this reason, the reimbursement model is usually accompanied by cost-sharing. The tendency to encourage overspending will be reinforced if well-meaning governments have established tax relief for health insurance premiums.

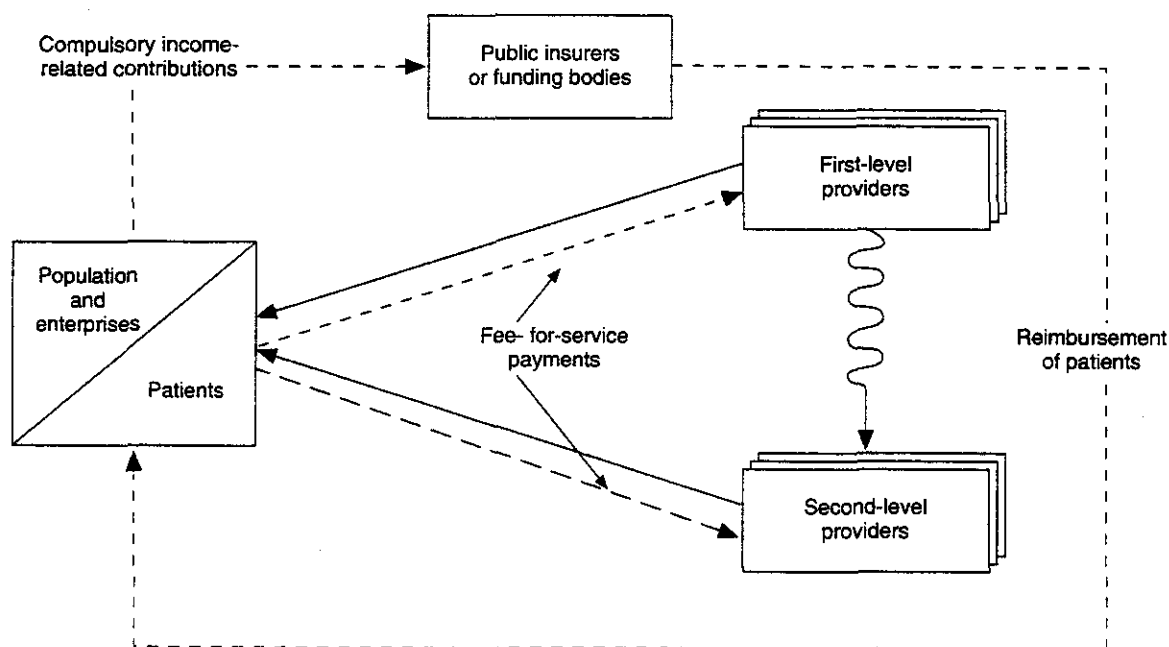
The second major drawback is that nothing will be done to tackle systematic inequities. Access to insurance will be in accordance with ability to pay. Profit-maximising, competitive insurers have an incentive to select against poor risks or to load premiums against them. Individuals with pre-existing conditions are likely to be refused insurance altogether for these conditions. If health care prices are raised by the workings of reimbursement insurance, low-income groups may be made worse off.

Although this model has been described as ‘conventional’ in deference to American literature, it was comparatively rare in Europe before public health insurance schemes were introduced. Rather, the dominant voluntary insurance models were of the contract or integrated type which provided benefits in kind – forerunners of health maintenance organisations (see below). Nevertheless, the reimbursement model often found a role after public schemes were set up. Arrangements approximating this model are now found in the private sectors in the United Kingdom and the Netherlands.

The public reimbursement model

The equity and risk selection problems of voluntary health insurance can be countered by public insurance with compulsory risk pooling, income-related contributions and subsidisation of contributions for the poor (‘solidarity’). Chart 2.3 shows public insurance based on the same reimbursement principles explored above, with: direct, fee-for-service payment of providers by patients; compulsory, income-related contributions; non-competing sickness funds or funding bodies; no connections between sickness funds and providers; and reimbursement of patients by sickness funds for medical care bills according to the benefits of the scheme. There may well be cost-sharing between the patients and the insurers. Although there can be multiple sickness funds for different occupations, industries or localities, and even consumer choice between funds, there must be uniform

Chart 2.3 Compulsory insurance with reimbursement of patients



These systems, and alternative methods of government regulation, are detailed below.

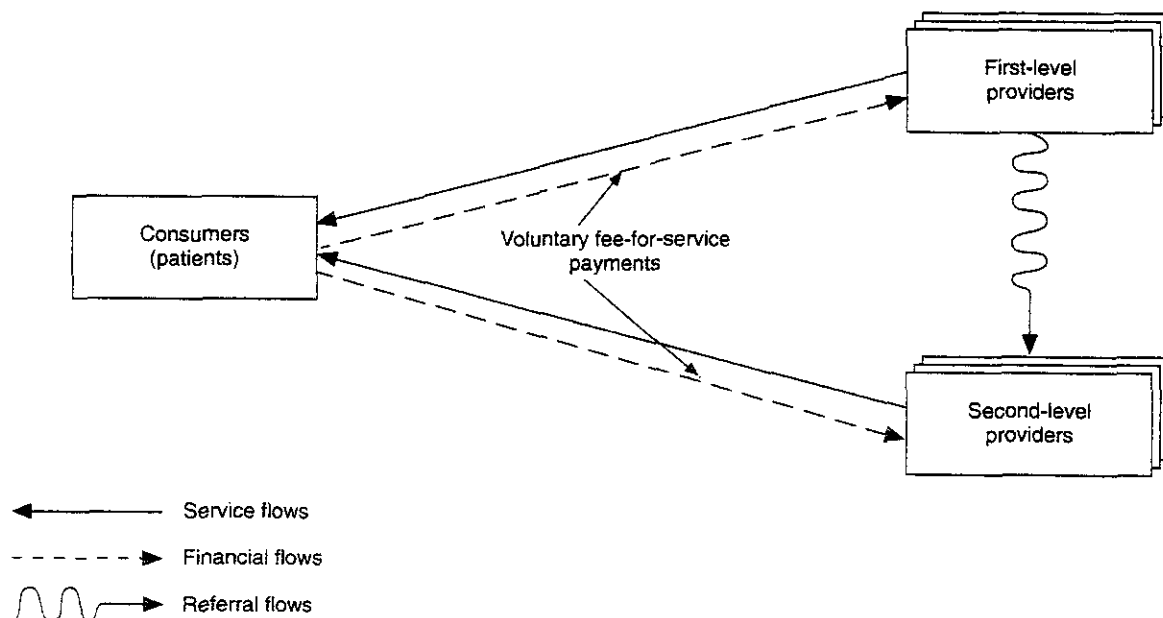
Certain other distinctions will be introduced which play a supporting role in this taxonomy. First, compulsory third-party payment systems divide into: those which are funded mainly by payroll contributions and are administered by quasi-autonomous sickness funds; and those which are funded mainly by general taxation and are administered by central or local government funding bodies. Second, methods of paying professionals divide into: fee for service (payment for each act); capitation (payments for each registered or enrolled client per period of time); and salary (payments for each period of time). The first two methods may be described as work-related, or as allowing "money to follow the patient" – this is truer for fee-for-service than for capitation. Third, methods of paying hospitals divide into: payment per case; payment per day; and prospective, global budgets. Again, the first two methods may be described as work-related or as allowing "money to follow the patient". Finally, health care providers divide into: independent professionals and institutions; and public employees and institutions. This last distinction, however, becomes blurred when it comes to salaried doctors who retain their professional autonomy.

The voluntary, out-of-pocket model

Chart 2.1 shows the simplest and earliest form of private, health care market without insurance but with direct, out-of-pocket, fee-for-service transactions between consumers (on the right) and first- and second-level providers, respectively (on the left). Solid lines show service flows, broken lines show financial flows and wavy lines show referral flows. First- and second-level providers are shown as multiple, to indicate that there is generally consumer-led competition between them (often subject to restrictions on advertising and on price competition and other restrictive practices). Chart 2.1 could also be used to depict cost-sharing under voluntary or compulsory health insurance, if it were blended with Charts 2.2-2.7 below.

Out-of-pocket payments depend on ability to pay. Where income is inadequate or where health expenditure is unexpected and catastrophic, the model will not be consistent with adequate or equitable access to health services or with adequate protection of income. Putting aside these distributional and risk issues, the achievement

Chart 2.1 Voluntary, out-of-pocket payment for health care



- Inappropriate financial incentives for providers;
- Harmful monopolistic and restrictive practices exercised by providers;
- Unsuitable organisational and management structures;
- Poorly designed regulation mechanisms; and
- Remediable gaps in information about effectiveness and costs.

The precise problems, here, vary between the countries and it is in areas such as these that governments have concentrated their reform efforts.

However, although these factors are potentially amenable to reform, governments are hampered in tackling them by their incomplete understanding of what combination of incentives and regulations best motivates providers. No entirely reliable guide exists as to the behaviour of doctors or large non-profit organisations such as hospitals. In the case of doctors, at least three plausible models of their behaviour have been advanced (Tussing, 1985):

- The "agency" model, in which the doctor supplies technical expertise and acts solely in the interests of the patient. In the case of out-of-pocket payment, this will include helping the patient to choose treatments which balance the likely benefits of care against the likely costs;
- The self-interest model, in which the doctor is motivated significantly by the desire to maximise some combination of his or her own income and leisure;
- The medical ethics model, where the doctor is motivated primarily by the desire to do as much as possible for the individual patient at hand, irrespective of the cost.

The study proceeds on the assumption that the behaviour of most physicians is driven by a mixture of these motives. Accordingly, much of the report is concerned with the search for arrangements which will reward doctors and other providers, both financially and professionally, for pursuing their traditional concern with the welfare of patients and for taking account of costs. In other words, it is concerned with encouraging behaviour which is cost-effective from the point of view of society. Fortunately, it can be shown that there is no inevitability of conflict between medical ethics and economic efficiency (Williams, 1989).

Governments are also handicapped in introducing reforms by formidable political obstacles to change and by difficulties with implementing reforms in large public systems. Even when they are convinced about the technical superiority of fresh arrangements, governments are not always in a strong position to introduce changes. A useful model of the political structure of the health care system distinguishes between three main interest groups: consumers; administrative rationalisers; and professional monopolists (Alford, 1975). The consumer is often the weakest and the professional monopolists are often the strongest. Standing behind the administrative rationalisers, governments are often obliged to approach health care reforms with caution. This is especially true when, as frequently happens, the consumers take side with the professional in opposing change.

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However, special characteristics of the demand for and supply of health care have discouraged, and presumably always will discourage, OECD countries from relying solely on the free market combined with income redistribution for the provision of health services (Culyer, 1989).

First, the requirement for income redistribution is particularly pressing where health care is concerned. This is because opinion is widespread and firmly held that medical care of good quality should be available to all who need it without their suffering an unacceptable financial burden: there are "caring externalities". Moreover, a strong inverse relationship often exists between ill-health and the ability to pay for health care. Private charity is unlikely to provide an adequate means of meeting this demand for altruism, partly because of the "free rider" problem: each individual is tempted to leave the burden of giving to others.

Second, the need for health care is often highly unpredictable and very costly for the individual, although it is predictable and affordable for large groups. Insurance can be used to help to spread the burden of payment but private insurers will have an incentive to exclude, or raise premiums against, high-risk individuals – that is to say against those who are most sick, who will often be those with the lowest income (risk selection and premium loading). In general, those with pre-existing conditions will be refused insurance for these conditions. It is not easy to devise income redistribution mechanisms based on market principles which can cope with this. Moreover, health insurance brings a tendency towards over-consumption. Neither the patient nor the doctor has an adequate incentive to economise when a third party is paying the bill (moral hazard). Although private institutions such as health maintenance organisations have been devised to tackle moral hazard, they do not seem to be capable, in themselves, of tackling risk selection.

Third, the consumer is in a weak position in the market for health care. This is partly a result of asymmetry of knowledge. The consumer may know when he or she feels sick but is usually too ignorant to judge what can best be provided by way of remedies and to judge retrospectively the quality of care, because of the complexity of medical technology and the relative infrequency of much consumption. In addition, sickness can itself impair judgment. For these reasons, the consumer is obliged to rely heavily on the advice of the doctor and to obtain medical approval for making most major consumption decisions. In these circumstances, it is often the doctor who takes the decisions. It is not easy to maintain consumer sovereignty in these circumstances.

Whereas other markets for goods and services possess one or two of these characteristics, few, if any, possess all three.

STRENGTHS AND WEAKNESSES OF GOVERNMENT INSTITUTIONS

The difficulties with relying on the private market for health care have encouraged governments – to a greater or lesser extent – to intervene in the financing and delivery of health care. However, whereas government actions may cure or moderate the original defects to which they were addressed, they often bring unwanted side effects.

One widespread form of intervention has been the introduction of public financing of basic health care, for some or all of the population. This has been done, for example, by means of compulsory health insurance schemes financed by income-related contributions. Schemes can include low income and vulnerable groups, often with the help of tax subsidies. Such arrangements can be very successful in improving access to health care and income protection for disadvantaged groups. However, they have often succeeded at the expense of unacceptably high levels and rates of increase of public expenditure. This has been especially true when they have been developed in the shadow of private health insurance schemes.

Another common form of intervention, often introduced, in part, to tackle the side effects of the first, has been government regulation of private or mixed markets of health insurers and providers. To some extent, governments have encouraged self-regulation. For example, one early and crucial development in most countries was the professionalisation of doctors and other highly skilled health care workers. Governments granted doctors and other health professionals certain privileges of self-regulation and a collective monopoly of supply, in exchange for the adoption of ethical forms of practice and the maintenance of certain standards of qualification and practice. In addition, governments have promoted self-regulation by pro-market, or pro-competition policies. To a considerable extent, however, regulation has been of the command-and-control type, with centralised attempts to limit the rate of rise of insurance premiums, to fix the prices, quantities and quality of health services and to plan and control capacity. Such regulation seems to be capable of controlling costs, if it is applied with sufficient determination. However, it suffers from well known tendencies to become over-bureaucratic, to impose distortions and rigidities on markets and to suffer capture by the regulated industry. Where medicine is concerned, government sovereignty appears to be no more straightforward than consumer sovereignty.

Chapter 1

INTRODUCTION AND MAIN ISSUES

INTRODUCTION

OECD Member countries continue to face persistent difficulties with the financing, delivery and performance of their health care systems, despite the successful implementation of new policies since the mid-1970s. This report considers the ways in which these problems are being tackled in seven OECD countries. It is addressed to governments in OECD countries in general because of the responsibilities which they all carry for the financing, regulation and provision of health services.

The report approaches these issues through a comparison of recent and prospective reforms to the health care systems in the selected OECD countries. Usually, much may be learned when countries reform their health care systems. This is a time when policy-makers think carefully about objectives, about existing health care institutions, about the causes of the problems which face them and about the available solutions. Despite the well documented differences which exist between countries in medical culture (Payer, 1989), in health care institutions (Raffel, 1984), and in medical practice itself (McPherson, 1989), international comparisons of subsequent reforms can shed light on common problems and common solutions. OECD countries share similar health policy objectives; the apparent diversity in their health care financing and organisation arrangements disguises the fact that each system is made up from a fairly short list of sub-systems, a few of which tend to dominate. These points will be developed more fully in this chapter and in the chapter which follows.

The countries which were selected for this study are all in Western Europe. They were chosen for a mixture of reasons including: the importance of the reforms they had made in the 1980s or were contemplating in the 1990s; the extent to which they represent the different types of health care system found among OECD countries; the willingness of their administrations to participate in the study; and the economy of conducting the investigations in one continent. In addition, the study draws on experience from North America. The countries fall into three main groups which represent most of the main health care systems found in OECD Member countries:

The Netherlands	financed by a mixture of social and private insurance, with mainly private providers;
Belgium, France and Germany	financed mainly by social insurance, with mixed private and public providers;
Ireland, Spain and the United Kingdom	financed mainly by general taxation, with mainly public providers.

An important distinction in health policy has to be made between the production of health services and the production of health itself. The health of the population depends not only on health care, but also on many other factors which include standards of living, housing, life-styles, diet and environmental circumstances. This study confines itself to the production of health services, and to the effect which those services have on the health of the population, other things being equal. In other words, the study concentrates on the financing, organisation and results of preventive medical care, primary medical care and hospital care – all forms of care which involve doctors, nurses and other medical and paramedical professionals. The study does not deal with health promotion in the wider sense or with dental care. Neither does it consider in any great depth the arrangements for long-term care, particularly those at the boundaries between health services and social services.

The purpose of this chapter is:

- To set out some of the main objectives of health care policy;
- To discuss the strengths and weaknesses of free markets and government institutions for health care; and
- To introduce some current problems with the financing and delivery of health care in the countries included in this study.

research could include:

- minimum data requirements used within member states for waiting times and waiting list purposes and suggested common data requirements;
- the impact of waiting times on health outcomes;
- equity of access on an age, sex, ethnic or socio-economic basis;
- the impact of waiting on vulnerable groups such as the mentally ill or developmentally handicapped;
- a comparison of actual waiting times in health care within member states;
- systems for setting criteria for treating patients;
- booking and admission systems in hospitals;
- communication between hospitals, patients and referring doctors about waiting times;
- delays in informing the referring doctor or specialist of symptoms;
- access to specialist care and its impact on waiting times and waiting lists;
- the relations between waiting times and funding mechanisms for health care;
- cost-benefit analysis of the impact on the economy and society of time spent waiting for elective care;
- definition of waiting times used in member states.

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review and validation of waiting lists in order to ensure that they remain an accurate account of patients waiting for treatment.

Informing patients

17 Information about the patient's booking and waiting time situation shall be given directly to the patient, and if the patient has been referred by a doctor, also to this doctor:

- as soon as possible after the hospital has received a self-referral or referral from the doctor;
- at regular intervals, if a booking date has not been established;
- on each request.

18. Ideally, patients should be informed of their admission date at the time when a decision is made to admit them. This may not be possible in all cases, but all patients should be given a realistic estimation of waiting times and of the arrangements made for notifying them of their admission date.

19. Patients are entitled to have adequate information on waiting lists and waiting times in specific settings. They should have access to individualised information about their own ranking on a waiting list through a named contact within the relevant institution. Patients should be able to obtain guidance and assistance from statutory bodies or consumer organisations when interpreting such information and, where the system allows this, enables choices to be made about alternative options for treatment.

20. There should also be a requirement on patients to contact the clinic or hospital if they have decided that they no longer need the treatment, have moved or are unavailable for admission due to family or work commitments.

Informing staff

21. To assist in the organisation of services, the information systems used at institutional level to monitor waiting times should be based on the process of provision of patient care and include data on the following:

a. Waiting lists (booked and non-booked patients):

- number of patients waiting for preliminary contact (outpatient appointment, waiting for diagnosis) in different specialities and, where possible, clinical priority group and prospective diagnosis;
- number of patients waiting for treatment in different specialities and where possible by clinical priority group and intended treatment or procedure;

b. Measures of productivity in relation to the number of patients on waiting lists, for example the numbers of admissions from waiting lists and the use of beds and operating theatres;

c. Patient non-attendance;

d. Quality measures, especially when efforts are made to reduce waiting times, such as readmission rates, unplanned admission rates and mortality rates;

e. Waiting times:

- actual waiting times for the patients waiting on a given date, for example the last day of every month or quarter;
- actual waiting times for the flow of patients who have been treated in a given time period, such as a year;
- expected waiting times for referral or treatment based on data for patients actually treated, such as the distribution of actual waiting times or an average waiting time.

In addition the whole waiting time from initial referral through to treatment should be kept under review.

Informing the public

22. Information about the waiting time situation should be open to the public, including referring doctors without prejudice to the data protection requirements. This could include standardised information at national and regional levels, but should include information on waiting times at:

- ensure that the recommendation is brought to the attention of all the relevant actors;
- adopt the legislative or other measures necessary to give effect to the principles set out in the appendix to this recommendation.



■ Appendix to Recommendation No. R (99) 21

■ General considerations

1. The health care systems in European countries are experiencing both increasing expenditures and rising demands for their services. In most countries there is a gap between what health services are able to do and what they can afford to do. One consequence of this is that some patients face delays, or waiting times, before getting specialist care and there can be waiting lists for some services. European countries have different health care systems that exist in varied political and cultural environments. The channels through which patients have access to specialist care also differ between member states and there are contrasting degrees of public and private provision and funding. The emerging issue in some countries is a risk of fast-tracking when employers send their employees directly to special services, not accessible to other patients (or register them earlier on waiting lists). The organisation and provision of health care is an important factor to consider when examining waiting times and waiting list issues. This recommendation does not deal with the issue of waiting lists for organ transplantation

2. Waiting times and waiting lists give focus to particular parts of the health care system, mainly elective surgical care, but they can not be seen in isolation. Policies to address waiting times will need to reflect the relative priorities for achieving improvements in the whole health system, including self care, social care, primary care, preventive care, secondary care, rehabilitation and long-term care.

Policies to address waiting times will need to bear this in mind, as other services otherwise may suffer, including:

- preventive care;
- care for the elderly;
- psychiatric care;
- primary health care;
- rehabilitative services, etc.

Appropriate management of waiting times and waiting lists (where they exist) may also prevent patients from going abroad to receive care.

3. Waiting lists and waiting times are quality issues and work to reduce delays in access to care should be part of the quality improvement system or program, both at institutional, regional and national levels.

4. Waiting lists and waiting times are not necessarily representative only of the need for health care, but may reflect various aspects of the health care environment and organisation. The existence of such a system usually translates society's wish to ensure a fundamental principle: that access to health care should be available to all according to their needs, and regardless of their ability to pay.

In a system of liberal medicine, based on supply and demand, the use of waiting lists as an instrument for prioritisation does not usually exist, and preference tends to be given to other instruments aimed at reducing demand, such as co-payments.


The waiting lists may reflect an increased demand and higher expectations. They could also be manipulated by the managers and by hospital staff, especially in smaller units.

5. A goal of waiting times policies should be to ensure that access to treatment is based on transparent criteria, agreed at national level, that address the risk of deterioration both in clinical (pathological) and quality of life (functional) terms. These criteria determine thresholds for providing treatments or for determining priorities once patients are on a waiting list.

6. There is no single explanation for the existence of waiting times and it is important that their causes are

As the data contains confidential information, it is important that only the central authority have full access to the register. When data is supplied to external sources identifiable information, as e.g. social service number must be encrypted, in order to observe the law of registers and to avoid misuse of the register.

Furthermore, the transmission of the data must be secured. To prevent outsiders from reading the sensitive information, either by mistake or on purpose, an encryption mechanism must be implemented in the transmission of the data, which ensures that only the approved recipient of the data is able to read them.

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- The design of administrative systems employed.
- Information requirements for managing waiting lists, including minimum data set
- Information requirements for monitoring waiting lists.

Implementation

- The production of guidance notes for staff.
- Training of staff: clerical, managerial and clinical.
- Monitoring compliance with procedures.

Review

- Arrangements for the review of waiting list policies and procedures.

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Out-patients	In-patients
National Health Service number	National Health Service number
Patient name	Patient name
Address and postal code	Address and postal code
Health authority of residence	Health authority of residence
Sex	Sex
Birth date	Birth date
General Practitioner	General Practitioner
Overseas visitor status	Institution code
Institution code	Category: planned, booked or waiting list
Patient hospital number	Admission type: day case/ in-patient
Source of referral	Decided to admit date
Service type requested	Date offered for admission
Data referral request received	Admission offer outcome
	Elective admission removal date
	Elective admission removal reason
	Duration of elective wait
	Intended procedure
	Intended management
	Priority type, eg urgent, soon, routine
	Speciality
	Admitting Doctor



Criteria for the management of waiting lists and waiting times in health care

Health and Quality of Life



Modelling of waiting times and waiting lists

The use of modelling can help improve the understanding of the dynamics of waiting lists. Models can be developed and used to assess the impact of changes in referrals, additions to waiting lists and admissions from waiting lists.

A simulation model can be described as the building of a replica of a complex system where alternative courses of action can be tried out using the model and the consequences can be assessed. "What if" questions can be assessed, for example: "What growth in admissions would be required to achieve a given target for improving waiting times in a given period." A model could be used to investigate the effect on waiting times of increasing admissions on a one off basis, of increasing admissions on a regular basis and of an increase or reduction in demand represented either through referral rates or additions to waiting lists.

Simulation modeling can help avoid or minimise the making of expensive mistakes by avoiding experimenting in the real domain. They can also provide a useful tool for communication between the participants in the provision of health care.

Models can also be of value to hospitals as they can be used to reduce bottlenecks and improve patient throughput, for example in Outpatient or Accident & Emergency departments. Applications of waiting times simulation models include linking them to other simulation models to examine the effects of changes in emergency admissions, staffing levels or operating room and bed capacity.

Key data required are: referral levels, numbers currently on waiting lists, the distribution of waiting times, additions to and removals from waiting lists and admissions. Models can be populated with data at the national, regional, hospital, clinical speciality or individual specialist level.

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Information on waiting lists and times is important for improved management of hospital services. Data should be collected for use in monitoring current performance, forecasting the future position and modelling different possible scenarios. Comparative information can be shared with specialists to identify scope for improving service provision. In order to be most useful, information on waiting lists needs to be looked at in context of other hospital activity and utilisation data such as bed occupancy, average length of stay, cancellation of operations, theatre usage and emergency admissions.

Monitoring waiting lists

Consideration should be given by national authorities to establish arrangements for the monitoring of waiting list and waiting time information. Such arrangements should focus on the time waited by patients. The total number waiting may also be of interest. Regional and local authorities responsible for funding hospital services should participate in these arrangements in order that they can use any data required nationally to monitor performance in this area.

The balance of data to be obtained locally and nationally will need to reflect national policies for data collection from providers of health services.

Addressing long waits

It is important that patients with the greatest clinical need receive treatment first and that fair systems are in place to determine admission to hospital. It is also important to ensure that patients are treated within a reasonable period of time. Maximum waiting times will reflect the balance between the demand for and the supply of hospital services. Consideration should be given to setting out limits within which it is expected that hospitals should admit most patients. These could take the form of a maximum limit requiring all patients to be admitted within a certain time period. Alternatively time limits could be set for a range of priority procedures or client groups (e.g. cataract surgery or children). Another option is to set a percentage (e.g. 95%) of patients to be admitted within a given period rather than requiring this for all admissions. A view needs to be taken as to whether to pursue reductions for all diagnoses and operations or to target specific conditions.

Techniques to address long waiting times include:

- establishing waiting times policy as part of quality management and the normal planning process, with targets set annually for improvement;
- identifying procedures for which a number of specialists can agree to pool capacity so that patients with the longest waits can be admitted as admission dates become available;
- not to lose sight of the "tail" of long waiters. Identify them and ensure that admission dates are offered;
- the setting aside of an agreed proportion of operating theatre time to admit long waiting patients;
- increasing the provision of ambulatory care thereby releasing beds for long waiting cases
- offer long waiters the chance to transfer to another provider;
- develop models of bed state availability within hospitals and plan elective admissions during times of lower emergency admissions;
- develop incentives for primary care teams and hospital departments which reward improved management of waiting lists;
- look at elective services as part of a whole systems approach, not as stand alone waiting list initiatives, e.g. by developing rehabilitation services to free up acute beds;
- evidence is available to suggest that the current levels of some operations could be reduced in number (e.g. grommet insertion, D & C for women under 40, tonsillectomy). Waiting list plans should include protocols to improve the appropriateness of these interventions;
- look to increase the scope for managing non-urgent cases in primary care, e.g. by holding non-urgent waiting lists by GPs;

Data can be developed at the level of clinical specialities or in more detail using operation codes or at diagnostic level using ICD-10 classifications.

Access to waiting lists

Access to specialist services will vary between countries. In those systems where patients are first seen by a General Practitioner and then referred to a specialist, the development of referral guidelines can assist in *ensuring that only patients who require a specialist opinion are referred*. (These comments also apply to specialist to specialist referrals as well as those from private specialists based outside hospitals who are under contract to a public health system). In systems where patients can access outpatient clinics directly then consideration should be given to the development of guidelines for patients to discourage inappropriate attendances.

Guidelines can either be developed nationally for local use or can be developed after discussion in a locality following agreement between specialists and GPs. A sensible starting point is to develop guidelines for procedures which are either very common or have long waiting times. GPs should be provided with information, at least quarterly, on outpatient and inpatient waiting times of clinical departments at local hospitals. If possible the particular interests (e.g. joint replacement or hand surgery) of surgeons should be indicated. Where waiting lists are held by individual surgeons and physicians then the information should also be presented at that level of detail. Hospitals should provide information back to GPs (or the doctor who referred the patient) on rates of referral to specialist services.

Booked admissions

Ideally a patient's admission date should be agreed and booked at the same time as a decision is made that hospital treatment is required. This removes a considerable amount of uncertainty for the patient, can assist in *planning the use of operating theatres and beds and help reduce the incidence of patient non-attendance*. Waiting time policies will need to address the waiting times of patients both with and without admission dates and waiting list totals should include both groups of patients.

Selecting patients for admission

Patients should only be added to a waiting list if, in the view of the doctor treating them, their condition is stable and does not warrant immediate admission to hospital. An addition to a waiting list should only be made once a patient has accepted the advice of a specialist that hospital treatment is required. Patients should not be added to a waiting list to reserve a place against the possibility that in the future treatment might be warranted. Such patients should be kept under review either as outpatients or cared for by their GP until their condition requires admission.

A waiting list policy should include criteria to be used by doctors when decisions are made about admitting patients. Setting out objective criteria is an important means of demonstrating fairness in accessing hospital services and ensuring that patients with the greatest clinical need receive treatment first. Various methods have been developed. Some approaches require the specialist to rank the patient in one of four categories: immediate, urgent, soon or routine. More objectively rankings could be determined based on criteria such as: progress of disease, pain, disability or dependence on others, loss of usual occupation and other social factors. Where there are patients of equal priority preference should be given to patients with the longest waiting times, including any time waited as an outpatient. Accordingly, consideration should be given to keeping the date of receipt of the original outpatient referral in data sets for inpatient waiting lists.

Communication with patients

Patient perception of the quality of health services can be influenced by the amount of communication received during the referral and admission process. When a patient is added to a waiting list it is good practice to obtain the following information: confirmation of the patient's address, both home and work telephone numbers, whether patient is available to come in at short notice, any special circumstances (e.g. caring for elderly relatives) and any dates when the patient will not be available for admission. Printed information should be given to the patient with details of the waiting list and admissions process and a contact telephone number along with appropriate information about their condition and intended procedure. If a decision is made to admit a patient to hospital then this should be communicated to the patient's General Practitioner, or the doctor who sent the referral. The provision of reply slips with outpatient appointment letters and admission letters can improve attendance.

Structure of waiting lists

Waiting list data should be available for each specialist. To aid both the clinical and administrative management each specialist's waiting list should be sub-divided into a number of smaller lists. *For example these could differentiate between individual operation groups, reflect the nature of the surgery required (e.g. major or minor)*

shown below:

Priority Group I: Basic health care

(Conditions A, B and C must be met)

A Health state (at least one of the following conditions must be met):

1. Loss of prognosis: The risk of dying from disease within five years is greater than 5–10 per cent
2. Diminished physical or mental functions (or a significant risk of such a reduction): permanent and significant reduction in the patient's ability to perform tasks which he/she would generally perform in everyday life (occupational activity, schooling, housework etc.), or tasks which patients in the same age group would naturally perform
3. Crippling pains that cannot be reduced sufficiently with the aid of non-prescription painkillers. One indication of strong pains is the diminished ability to carry out work and perform ordinary everyday activities (dressing, hygiene, sleep, cooking etc.)

The term permanent means that the patient's state of health is not expected to improve without treatment

B Expected benefit (at least one of the following conditions must be met)

1. Increase in the probability of five-years' survival is greater than 10 per cent (absolute risk reduction)
2. Improved physical or mental functions: Complete or partial restoration of previous state of health
3. Reduction of pain which leads to improved level of functioning
4. Nursing and care that can secure adequate nutritional intake, natural functions, hygiene, dressing and the opportunity for external stimulus or social contacts

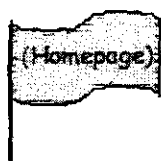
C Cost-efficiency

Costs should be in reasonable proportion to the benefits of the treatment/care

Priority Group III: Low-priority care

Low priority may be given to:

- Health states where the patient can assume responsibility for himself
- Health states that result in an insignificant reduction in the level of the patient's physical or mental functions
- Care/treatment that has minimal expected benefit, i.e. less than a five per cent increase in the patient's chances of surviving for five years (or an improvement in the chances of survival which are impossible to prove using recognised statistical methods), or treatment that does not lead to an improvement in the patient's physical or mental functions for a certain period of time
- Treatment/care with a dubious medical effect, i.e. poorly documented
- Measures that are too costly in relation to their benefits
- Nursing and care that goes beyond securing life functions and maintaining a level of physical and social activity which is "normal" for the patient. .



Criteria for the management of waiting lists and waiting times in health care

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Referral, Selection Criteria and Priorities

■ Referrals from General Practitioners to hospitals

In systems where access to specialists for elective treatment requires referral from a GP then it is important that patients, GPs and specialists are working within a common understanding of how the process works.

In the period from the time of the GP referral to the hospital until the patient is actually examined or treated in the hospital there is a risk that the patient «falls between two chairs», meaning that neither the GP nor the hospital takes responsibility for the patient. It is necessary in this period for responsibility for the patient to be clearly understood. This should include the provision of information to the patient (and GP) about when he/she will be seen in the hospital and what action should be taken if the patient's situation changes. The patient may get worse and need treatment quicker than the hospital is expecting from the information in the GP referral, or the patient may get well and not need treatment at all.

In most European countries hospitals are responsible for the selection of patients to be seen in out-patient clinics by a specialist, whether patients are referred by a GP or contact the hospital directly. A development in Spain is that GPs are responsible for selection of patients to be seen in out-patient treatment in the hospitals funded by the Ministry of Health. The GPs are informed by the hospital when there are free appointment times for patients in the different out-patient clinics. The GP then books the appointment for the patient, and is in this way responsible for the selection of patients to be seen in clinics.

■ Standardised referral information from GP to hospital

To assist specialists in making choices about which patients to admit, and what priority to assign to them, it is necessary for appropriate information to be available for the group of patients seen in clinic. The amount of information in GP referrals can vary considerably. Ranging from a note with one word and a question mark (for example: Ear?) to a focused referral with all the necessary information including a clear problem for resolution or a print-out of an electronic journal of several pages with no clear problem stated. It is difficult to prioritise between patients if the relevant information is not provided to the specialist. This problem can be addressed and a standardised referral letter is one way to achieve this. Committee members reported of initiatives within their country at both local and national level.

Development of selection criteria for admission

Individual departments or specialists within a hospital generally have in practice criteria, perhaps informal ones, used when admitting patients to hospital. The Committee considered that it would be beneficial if these criteria were standardised and made available publicly. In developing criteria a view needs to be taken as to the level at which these would be agreed: national, regional, local, institutional or department. The Committee concluded that ideally national criteria should be developed that could be applied locally. Approaches to define selection criteria at national level would need to involve the various interests within the health system:

- Government (as funding agency, regulator and representative of the tax payer)
- Producer (individual clinicians, hospital management, medical professional groups)
- Citizens (current and potential patients as well as tax payers)

The Committee concluded that socio-economic and demographic factors should not be included as criteria for determining access to health care. However, it was considered to be important to monitor admissions to hospital to ensure that waiting lists are not being used as a means to deny access to hospital to the more vulnerable groups in society.

Basic ethical guidelines regarding equity must be taken into account:

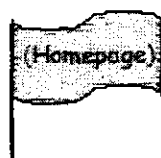
- need and urgency should never be determined on the basis of race and religion
- age and sex should not determine priority and ranking either; they may only be taken into account as an aspect of the general medical condition of the patient and as a risk factor.

Economic interests should not entitle to preference or priority in admission. Especially not the economic interests of others than the patient himself (employers, third parties, governments, etc.)

Access to ranking information:

- Consumers are entitled to have adequate general information on waiting lists/times in specific settings. They should have access to individualised information about their own ranking.
- The general information must be transparent, standardised and accessible:
 - transparency for individual choice;
 - compatibility of uniform registration systems.
- Citizens/patients should be able to get guidance/assistance when interpreting waiting list/time information for personal use and choice.
- Organisations of patients and consumers should be involved in dissemination and interpretation of waiting lists information and in monitoring capacity problems. They are entitled to get transparent information on waiting list policies.

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Criteria for the management of waiting lists and waiting times in health care

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Consumer's role and patients' rights

■ Solidarity and quality

Waiting lists and waiting times have medical, organisational, financial, ethical and legal implications. These are linked to the political and legal principles that govern health care systems including solidarity, quality of care, freedom of choice and the public's right to know.

There is also the individual dimension, that of the patient waiting for treatment. There will be competing interests and perspectives within health care systems but that of the patient should be of main importance.

Patient's needs and urgency in terms of acceptable waiting time and ranking on waiting lists should be determined on the basis of fairness and urgency according to evidence based medical criteria which include the patient's condition and risk factors, emotional and psycho-social criteria and the patient's quality of life.

Despite differing health care systems there is a basic concept of solidarity in health care across the member states. The United Nations Universal Declaration of Human Rights states, in article 25, that "everyone has the right to medical care and necessary social service ... and the right of security in the event of ... sickness and disability...". This has been developed in other Charters, for example the Council of Europe's Convention on Human Rights and Biomedicine recommends that member states provide "equitable access to health care of appropriate quality".

Equitable access should not be confined to absolute terms of ensuring that no one is denied access but it is also a matter of scale and timing. Appropriate quality also implies that services will be delivered at the right time. Timing is an aspect of appropriateness and is related to the effectiveness of an intervention as well as to the amount of suffering, discomfort and risk for patients.

■ Timing and urgency

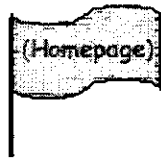
Where waiting lists have waiting times that exceed reasonably acceptable lengths then problems of scarcity and priority arise. This should be dealt with on the basis of equity and equitable access with ranking on waiting lists determined in objective terms according to professional obligations and standards. These should include evidence-based risk factors of a patient's medical condition and the relative conditions of patients waiting for an intervention. As well as the pathology of a patient's condition certain emotional and psycho-social aspects should be taken into consideration when medical priority is monitored. This has to do not only with psycho-somatic risk factors but also with possible infringements on a patient's quality of life when a waiting time gets too long.

There can be a degree of subjectivity and arbitrariness in a physician's understanding of priority factors. These factors could probably not be fully standardised. However, some objectivity and transparency are needed, especially with regard to quality of life criteria. Health care professionals in many countries are trying to come to terms with these issues and there is a need for more research, interdisciplinary exchange and ethical discussion on them.

■ Non-discriminatory ranking

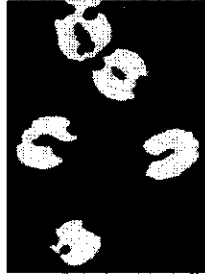
Apart from these individual and condition related aspects of priority and ranking by physicians and institutions there are basic fundamental aspects of equity that should govern access to elective care. Need and urgency should never be determined on the basis of race or religion. Neither should sex or age determine priority except when account needs to be taken of the general medical condition of a patient or as a risk factor.

A possible threat to equity on waiting lists comes from different kinds of economic interests. It should not be acceptable to buy preference on a waiting list. The offer of bribes to, or their acceptance by, professionals or institutions should not be tolerated. This would undermine the fundamental principle of equity of access. Attention also needs to be given to the activities of employers and third parties as funders of health care. For example employers could have a potential interest in seeking quicker treatment for their employees ahead of people that



Criteria for the management of waiting lists and waiting times in health care

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Information and Data on Waiting Lists and Waiting Times

Reducing waiting times and waiting lists requires addressing the issue as an element of improving the organisation and delivery of health systems. Such work is much more than an issue of collecting data however. Waiting times and waiting lists cannot be tackled in the absence of adequate information systems.

A waiting list, whether held on computer or on manual records, must contain enough information to assist their subsequent selection for admission and treatment. This information should be updated regularly. Each patient's record should include a minimum amount of data in common within the health care system. Ideally, all health care systems should have a minimum data set for patients waiting to be treated developed at the appropriate national or regional level. Examples of two such minimum data sets, from Spain and the UK are at [annex A](#).

A hospital's system should be sufficiently adaptable to accommodate changes in the data required for clinical or administrative purposes. The system should be flexible to enable records to be sorted, counted and presented as required by users who will likely be both medical and administrative staff. Staff responsible for recording and maintaining the data should be given appropriate initial training. This is especially important when staff retire or move to a new job and are replaced by someone unfamiliar with the record system.

Waiting lists fulfil two main functions. First, as a formal record of patients registered as requiring admission for treatment ensuring that patients do not get overlooked. Second, they provide a statement of known demand for treatment to assist the planning of hospital resources. Patients should only be added to a waiting list when they have accepted the advice of a specialist to have treatment. Specialists should not place a patient on a waiting list to reserve a place against the future possibility that treatment may be necessary. Wherever possible patients should be given a date for admission at the time when a decision is made to admit them. A waiting list for a hospital department or an individual specialist should have details of patients in different categories such as procedure type. This will assist in the planning of operating lists.

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It is not only the elderly that have higher expectations concerning health, quality of life, and the health care services. With new information technologies and higher living standards, people in general are more informed, demanding and impatient. These demands increase the pressures on health services.

■ **Concentration in certain surgical specialities**

From different studies of the nature of waiting lists we also know that they are more frequent in some specialities than in others. One such study of waiting lists in the UK in 1991 found that just under one half of all waiting occurred in general surgery and orthopaedic surgery. Three specialities; ear, nose and throat, gynaecology and ophthalmology made up a further quarter of the waiting. This pattern was repeated in many of the member states represented on the committee. Waiting lists are naturally concentrated in parts of health care that can be postponed in time, that is, elective care.

■ **Introduction of new technology**

In many cases it is also clear that a major explanation for waiting lists is the introduction of new technology, like improved anaesthetic procedures, laparoscopic surgery and total knee replacement. When there is a new technology it often becomes possible to treat patients that earlier could not been taken care of, and when the technology is introduced in routine care it is common that indications for surgery widens and demand expands even more. It is not always easy for the health care system to match rising demand with resources such as equipment and skilled personnel, and as a consequence there will be more patients on waiting lists. This has led some observers to believe that waiting lists are 'temporary' and the remedy would be to set aside resources and raise capacity for a limited period of time, and once a backlog of unmet demand was cleared waiting times and waiting lists would be shorter. The Committee observed that such increase in production can lead to even more demand, as the ability to benefit from treatments is expanded.

■ **Balance between routine and complex procedures**

However, not all patients waiting for care are waiting for a treatment that is at the frontier of technological development. Many of them are waiting for minor and well-known operations, such as varicose veins or enlarged tonsils. In those cases it may be that the doctors' priorities are in favour of treating more complex and challenging cases.

■ **Priority setting**

Patients waiting for treatment on a waiting list for special care, are not waiting only because they want to or they demand to be there, but rather, a doctor must have approved to put them on the list in the first place. Thus it is the doctors' perception of need and benefit from different treatments that is crucial for the decisions to put someone on a waiting list. Different doctors make different choices in practice about which patients to treat at what stage of morbidity. Some doctors may chose to put a patient on the waiting list at an early stage of the disease, while others rather will wait until the disease has progressed.

Priorities can also be set between different kinds of treatments so that one doctor finds it more efficient to concentrate on cataract surgery, when others choose to do check-ups on patients with diabetes. The crude surgery rates for different treatments vary within most countries, and a major explanation is varying practice patterns. The relationship between waiting lists and surgery rates, is however not very strong, and high treatment rates do not always mean that the waiting times are short.

■ **Perverse incentives**

In health care systems where a centralised budget model is used for the distribution of resources, there can be incentives for having long waiting lists, since many patients on waiting lists can be a sign of excessive unmet demand, and a motive for getting more resources. There are many examples of waiting lists that contain patients that actually do not need an operation because they have already been operated, they are not fit enough, or they have moved or died. One explanation for poor management of waiting lists in some institutions could be that a long waiting list is not seen as anything negative in the organisation.

■ **Improving process of care**

Waiting lists can also be caused by inefficiencies in production. If there are bottlenecks due to not enough resources in some part of the production process, it will not be of any help if other parts are well supported. If, for instance, there is a shortage of beds in which to put the operated patients, it will not be possible to do any more operations even if the surgeons have time to do more. Bed shortages can be a problem, not least because of the so called bed-blockers, that is, patients who do not any longer need the hospitals' resources, but do not have anywhere to go where they can be cared for, like a nursing home or home care. Another production related

The imbalance between available supply and demand in health services has led to a debate about prioritisation in most of the European countries. National guidelines for prioritisation have been drawn up in Denmark, Finland, the Netherlands, Norway, Portugal, Spain, and Sweden with local examples from the United Kingdom. Outside Europe developments have taken place in New Zealand, Ontario (Canada) and Oregon, (USA). A key issue in all these countries has been which, if any, criteria should form the basis for prioritising between treatments and how the criteria should be ranked in relation to one other. A common feature to such systems and proposals is the importance given to the expected benefit or effect of treatment/care and that for costs. The Danish, Swedish and Finnish approaches also recommend the criterion of demand, which in part overlaps with the criteria covering the gravity of the patient's state of health.

Common to all of the proposals to date is a regard for both the effectiveness and the cost-efficiency of the treatment. There is universal rejection of the notion that a patient's social characteristics should be relevant priority criteria, although employment status has been regarded as a criteria in some systems. Age in itself is only to a limited degree presented as a relevant priority criteria. The principle of equality and justice are stressed by all. Importance is attached to the evaluation of medical technology to identify which types of treatment are most effective, and should be given priority over the less effective treatments.

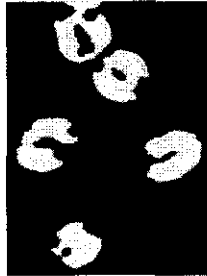
The debate on prioritisation would appear to be moving on from seeking to develop an overarching, centralised model of prioritisation, towards a more decentralised clinical approach to practical everyday decision-making based on a common framework which can be applied by all doctors. The Committee observed that although the development and application of such frameworks were still in their early stages, it is important that decisions about how patients access specialist care should be made by objective and accountable means.

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Criteria for the management of waiting lists and waiting times in health care

Health and Quality of life



Introduction

Scope

The Committee considered aspects of waiting in elective health care and did not look at issues around access for emergency care. Three aspects of waiting were discussed at the Committee's first meeting:

- Waiting for a consultation with a doctor in primary health care
- Waiting for hospital treatment both out-patient and in-patient
- Waiting for nursing care at home or a place in a nursing home

In principle, all of these areas are of interest when waiting times in health care are discussed. The Committee decided to focus the discussion on waiting times for accessing hospital treatment, as this is the topic that has the greatest interest in most European countries.

The Committee also decided to discuss the waiting times to the start of treatment (or examination) in hospitals, and not the waiting times during an admission to hospital, for example when an admitted patient is waiting in the x-ray department for the actual x-ray pictures to be taken. The Committee did not discuss waiting times within emergency rooms for the treatment of acute illness. Neither did the Committee discuss waiting times for organ transplantation as this was outside of its brief.

Background

The health care systems of European countries are experiencing both rising costs and demands on their services. There is a gap between what most countries health services are able to do and what they can afford to do. And this gap is growing. Important reasons for this growth are:

- Dispersed technology: The development of medical technology makes it possible to treat illness which could not be treated before;
- More chronic care: People who survive acute illness because of new treatment techniques become chronic patients;
- Demographic changes: People are getting older, and the elderly consume a relatively high proportion of health care;
- Changes in the pattern of diseases: for example there is a greater prevalence of both cancer and infectious diseases;
- The «medicalization» of our societies: problems are defined as health conditions that previously would not have resulted in demands for health care.

One of the results of these developments is that some people are experiencing longer waits before getting treatment as demand for medical care exceeds available supply. At the same time people generally expect better services in European countries, and this consumerism also applies to health services. There is an increasing focus on waiting times and waiting lists as an issue in many European countries. Patients and politicians, and often also the health care professionals, are very concerned about patients' waiting times.

The Committee is aware that in some member states patients can usually access specialist hospital services as



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Preface

European health care systems are faced with common problems due to a difficult economic environment. At the same time the demand for new technologies and sophisticated health care is increasing. This has led to waiting lists and waiting times for health care.

This phenomenon can have a negative impact on patients on a waiting list and is a challenge for both health care systems and their managers. Waiting lists and waiting times can put pressure on the principle of equity in access to available health care services. They can also have an influence on the health of patients. Health services that are compelled to put patients on waiting lists vary, as well as the multiple factors influencing this phenomenon.

In 1997, the European Health Committee (CDSP) set up a Committee of Experts on criteria for the management of waiting lists and waiting times for health care. The committee was asked to

- examine in general the current situation in the member States with regard to waiting lists and waiting times for health care
- explore the negative effects of waiting times on the health of the individual and describe the types of health care most subjected to waiting lists
- explore the main causes of waiting lists and waiting times taking into account both medical criteria for eligibility to get on the waiting list and the organisational and managerial aspects of the health services in question;
- consider current means of management of waiting lists and waiting times applied in various members States, the influence of funding systems and of medical criteria drawn up by the health professionals and the results obtained.

The Committee of Experts met three times on: 16-17 October 1997, 17-18 March 1998 and 17-18 September 1998.

It was composed as follows:

Chairman: Mr Colin McIlwain, Department of Health, Leeds, United Kingdom.

Consultant : Dr Petter Faye-Lund, Ministry of Health and Social Affairs, Oslo, Norway.

Secretariat: Dr Piotr Mierzewski, Administrator, Health Department, Directorate General III - Social Cohesion, Tel: 33 3 88 41 30 04 - Fax: 33 3 88 41 27 26. e-mail: piotr.mierzewski@coe.int

Belgium

Dr Pascal Meeus, Ministre des Affaires sociales, de la santé publique et de l'environnement, Service qualité des soins de santé, Bruxelles.

Denmark

Mr Claus Juhl, Head of Division, Ministry of Health, Division for Analysis and Research Policy, Copenhagen.

Finland

Dr Matti Pietikäinen, Chief Physician, Non-Institutional Care, Centre for Social and Health Care Services, Kuopio.

regarding the mix of public and private patients treated; and a written policy on planning the discharge of older patients and on liaising with community-based services.

Medium Term Recommendations: 1999

A number of steps should be taken during the course of 1999. These are summarised below.

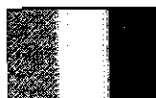
- ♦ WLI funding should focus on a limited number of specialties and take the greatest possible account of health and social gain, the priority set according to clinical judgement and the length of time already waited by patients.
- ♦ The present system of allocating WLI funding may act as a disincentive to hospitals to improve their waiting list performance. The Department of Health and Children should consider introducing positive financial incentives to hospitals to reduce their waiting times. A proportion of total WLI funding could be retained by the Department for distribution to the hospitals which showed the greatest reduction in waiting times in target specialties. The details of any such incentive system should be developed in conjunction with the relevant hospitals.
- ♦ Protocols should be developed in all major Waiting List specialties for the validation and prioritisation of cases. This should be done either at national level through protocols devised by the relevant professional bodies, or at local level by individual hospitals.
- ♦ A number of measures should be pursued to reduce the pressure from A&E services on acute beds. These include developing rapid diagnostic systems for common emergency presentations; developing effective care guidelines for managing conditions which no longer require admission; further developing treatment/observation areas to allow frequent review of certain cases; and improving access by general practitioners to urgent specialist opinion.

Long Term Recommendations 1999 - 2001

The availability of beds for elective treatments is being restricted due to a number of factors. These include shortfalls in the provision of services for older people (and others who may need long-term care) such as day investigation facilities, rehabilitation facilities, community-based support services and long-term residential care places. The shortfalls in these services result in inappropriate use of acute hospital facilities and thus severely hamper the ability of hospitals to provide treatments to patients on public waiting lists.

- ♦ The development of Geriatric Day Hospitals on the site of acute hospitals should be prioritised in the medium to long term. The next priority should be the development of rehabilitation facilities on acute hospital sites where they do not already exist. Both of these developments would significantly increase the appropriate utilisation of scarce acute hospital services.
- ♦ Each health board should evaluate the long-term residential care needs of its region. There should then be a planned programme of investment in appropriate facilities for those in need of long-term care.
- ♦ For acute patients, the case for providing stand-alone day surgery units on the site of acute hospitals should be examined closely. Since many patients who are on public waiting lists could be treated on a day case basis, a dedicated day surgery unit could greatly protect them from delays that arise from other hospital pressures.

Italy



Number of Doctors	101 000
Number of Inhabitants per Doctor	566
Number of Hospital Beds	380 000 (Population: 57.2 million)
Hospital Beds per 1 000 inhabitants	6.7
Total health expenditure as a proportion of GDP	7.6%
Health Funding	A balance of general taxation and compulsory contributions.
Health Insurance	Compulsory health insurance
Primary Care	GPs are independent and unsupervised and paid by district authorities on capitation fee for services and allowances.
Manpower	Among the lowest supply levels in Europe mainly attributed to the low planned density of GPs.

Luxembourg



Number of Doctors	1 000
Number of Inhabitants per Doctor	423
Number of Hospital Beds	4 600 (Population: 423.700)
Hospital Beds per 1 000 inhabitants	11.5
Total health expenditure as a proportion of GDP	7.0%
Health Funding	Mostly funded by state sickness fund with 28 per cent from state subsidies.
Health Insurance	Compulsory health insurance
Primary GPs	GPs are self-employed but are not permitted to practise outside the social security system. The insured patient is entitled to primary care from either a GP or a hospital specialist provided the doctor is covered by the Social Sickness Funds
Manpower	The level of supply is significantly below European standards. There are no medical schools in Luxembourg and all doctors receive their training in Germany France or Belgium.

Portugal



Number of Doctors	29 000
Number of Inhabitants per Doctor	348
Number of Hospital Beds	41 000 (Population: 9.8 million)
Hospital Beds per 1 000 inhabitants	4.2
Total health expenditure as a proportion of GDP	6.9%
Health Funding	Main funding from national insurance scheme with small private sector.
Health Insurance	Compulsory health insurance
Primary Care	GPs work in multi-professional community health centres and are paid on a salary basis.
Manpower	Despite an acceptable supply of physicians there are shortages in certain specialities such as anaesthetics ophthalmology and pathology.

Britain

Number of Doctors	95 000
Number of Inhabitants per Doctor	611
Number of Hospital Beds	260 000.
Hospital Beds per 1 000 inhabitants	4.5 (Population: 58.1 million)
Total health expenditure as a proportion of GDP	7.9%
Health Funding	Mainly from general taxation with a small but growing private sector
Health Insurance	Most services are provided free under the NHS but the private health insurance in tandem with the private sector.
Primary Care	GPs are independent contractors work ing mainly in group practices
Manpower	Currently there is a deficit of doctors of about .9 per cent and despite a growth rate of .5 per cent per annum this deficit is expected to increase.

Denmark

Number of Doctors	15 000
Number of Inhabitants per Doctor	360
Number of Hospital Beds	26 500 (Population: 5.2 million)
Hospital Beds per 1 000 inhabitants	5.1
Total health expenditure as a proportion of GDP	6.4%
Health Funding	85 per cent from general taxation with the remainder from co- payments
Health Insurance	Limited scope for private health insurance as most health services are provided free of charge by the state.
Primary Care	Independent GPs in solo or group practices approved and employed by the state.
Manpower	n order to ensure neither a shortage nor a surplus develops entry to medical schools and the medical profession is strictly regulated to match numbers with available posts

Finland

Number of Doctors	13 000
Number of Inhabitants per Doctor	392
Number of Hospital Beds	50 900 (Population: 5.1 million)
Hospital Beds per 1 000 inhabitants	10
Total health expenditure as a proportion of GDP	7.9%
Health Funding	Mostly by regional state authorities with added state subsidies.
Health Insurance	Most services are provided free but a private national sickness insurance scheme is also available
Primary Care	GPs are employed by local health authorities and are responsible for the health of a fixed number of persons. At present each GP is responsible for between 1 500 and 2 000 patients.
Manpower	Employment within the profession is not secure. Physician unemployment is 2.7 per cent and most junior doctors have non-permanent employment and can lose their jobs suddenly

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purchasing and provision of services (4). The national health committee resisted pressure to develop a simple list of services depicting what was in or out of the 'core' of services that would be publicly funded. Instead it defined eligibility for services in terms of clinical practice guidelines or explicit assessment criteria which depict circumstances under which patients are likely to derive substantial health benefit from those services, bearing in mind competing claims on resources.

The national health committee recommended that surgical services should move away from a system of waiting lists and toward a system of specific booking times, so that patients would know when they would receive their operation. A national project was initiated to put in place the tools needed to assess the extent of patients' overall priority or urgency for surgery. Priority would generally be given to patients with the greatest likely benefit. Five sets of standardised assessment criteria were developed for elective surgical procedures under the auspices of the project. Numerical scores were assigned to each of the multiple levels of severity on each criterion; relevant scores on each criterion were added together to form a total score. The procedures covered were:

- Cataract extraction
- Coronary artery bypass graft surgery
- Hip and knee replacement
- Cholecystectomy
- Tympanostomy tubes for otitis media with effusion

As well as clinical criteria several social factors were incorporated within the priority criteria to some extent. Age was incorporated into the criteria for coronary artery bypass graft surgery, on the basis that this type of surgery has direct implication for life expectancy as well as quality of life, whereas the other surgical procedures directly affect only quality of life. Threat to independence, care of dependants and ability to work were incorporated but given relatively little weight compared to clinical factors. Time spent on the waiting list was excluded mainly because the principal tenet of the criteria is that they reflect the degree of clinical (and social) likely benefit associated with the clinical condition, not time spent waiting.

On 8 May 1996 the minister for health in New Zealand announced the creation of an NZ\$ 130m fund to be used for clearing surgical waiting lists and replacing them with booking systems. Access to the fund was contingent on the use of explicit priority criteria such as, but not limited to, those developed during the project. The professional and public response was favourable in general.

Priority criteria for coronary artery bypass grafting were developed by a professional advisory group consisting of seven cardiologists, four cardiac surgeons, one physician and two general practitioners (19). The priority criteria were degree of coronary artery obstruction, class of angina, results of exercise stress test and ability to work, care for dependants or live independently. A clinical audit was conducted of all patients on New Zealand's waiting lists for coronary artery bypass grafting using the criteria. Based on the observed distribution of priority scores, the cost of providing surgery to all patients down to various levels of priority was estimated. Cardiologists and cardiac surgeons agreed that a threshold of 25 points was a reasonable clinical goal but to work with a threshold of 35, which could be sustained with the level of funding available. It was agreed that the gap between the clinically preferred and currently afforded threshold was a subject for wider societal dialogue and decision. The ability to measure the size of the gap between clinical desirability and financial sustainability provided a new transparency to the problem of healthcare resource allocation.

Dixon and New compare and contrast the approaches in Britain and in New Zealand (20). The

The author argued that monitoring and subsequent publication of post-referral waiting times would give a considerably more accurate picture for purchasers on the total length of time that patients have to wait for treatment. The inadequacy of the inpatient waiting lists as a measure of waiting times was particularly evident in conditions like cataracts and osteoarthritis, which need to reach a certain stage before surgery. The point at which these patients are added to the waiting list varies widely among consultants. Those who add their patients to the list at the first outpatient attendance will seem unfairly to have a longer waiting time than those who delay placing patients on the list until they are ready for operation. The total post-referral wait however may be the same in both situations. Careful monitoring is required to ensure that deferred patients are treated as soon as possible after the reason for deferral no longer exists. Stringent monitoring is essential to ensure that future reductions in the time waiting on true inpatient waiting lists are not gained at the expense of longer periods waiting to be placed on the lists and that no increase occurs in the number of patients placed instead on deferred waiting lists or exempted from the normal maximum waiting time guarantees.

A similar note of caution was sounded by the Radical Statistics Health Group who also illustrated that statistics in relation to the numbers of people on waiting lists may be open to misinterpretation (17). They highlighted that delays in making a decision to admit a patient can make recorded waiting times shorter. In addition patients who are offered a date but are unable to attend have their waiting times calculated from the most recent date offered. The numbers of these self-deferred cases are no longer published in the Department of Health's six-monthly statistical bulletin on waiting times. Data requested by the House of Commons Health Committee show that self deferrals rose from 48,343 during the period March to June 1988 to 66,901 during September to December 1993. More recent data showed that the upward trend in self-deferrals continued in 1994. Information on the numbers of people removed from waiting lists for reasons other than treatment was also excluded from statistical bulletins when their format was revised. Their numbers rose from 90,931 during March to June 1988 to 219,564 during September to December 1993. The median value of waiting times decreased very little between 1988 and 1993 in contrast with the dramatic reduction in numbers of people waiting over 18 months.

The authors recommended an extension to the collection of data about patients waiting for NHS treatment. The time of arrival of a referral letter to an outpatient department, the time of the initial appointment and the time between appointment and admission should all be recorded. This would reveal any delays in the system and would monitor the number of people waiting to join a waiting list.

Innovative approaches

A waiting list prioritisation points scheme was initiated at Salisbury District Hospital with the goal of making more explicit the criteria that consultants use to manage and schedule their inpatient waiting lists, and to facilitate factors other than time waited to determine a patient's place on a waiting list (18). Each patient on an inpatient waiting list is given 0-4 points in each of the following categories

- progress of disease
- pain
- disability or dependence on others
- loss of usual occupation (job, house, work, school)
- time waiting. Points are then squared to emphasise differences and summed to give a score out of a possible 80 points. The criteria chosen were arrived at through discussion between local consultants and GPs in the Wessex area.

local community settings and that the criteria for appropriateness should be linked with a commitment to audit. This would allow the standards given in the patient's charter to be achieved on the basis of need rather than political whim.

Newton, Henderson and Goldacre referred to policy initiatives in the NHS to reduce waiting times including the patient's charter, earmarked funds of about £30 million a year nationally from 1987 to 1993, and the funding of 100 new consultant posts in 1990 specifically to reduce waiting times (13). They examined national waiting list statistics from 1987-94 to determine how list size and waiting times changed in relation to changes in the number of admissions from the list. They also considered changes in the number of patients added to the list. They used local data to assess the impact of earmarked waiting list funds on admission rates, list size and waiting times at an individual district specialty level.

The national study showed that increasing admissions tended to improve waiting time but not list size. The local study showed that it was unusual for admissions to increase after an allocation of waiting list funds. Rather, allocations seemed to reduce list sizes without increasing admissions - possibly as a result of identifying patients on the list who did not require surgery for various reasons. The authors concluded that the objective of validation of the list alone could not justify the expense of these initiatives.

In contrast, Gray points to the reduction of waiting lists as one of the great success stories involving the reform of the National Health Service (NHS) in the United Kingdom (14). The author summarised the successes of the NHS in reducing the length of waiting lists. No one served by the publicly financed NHS has to wait two years for a procedure. Fewer than 4000 wait longer than a year and more than half the patients needing treatment are seen within 6 weeks of their first appointment with a specialist; 75% are seen within 6 months.

The shift of power from specialists to patients and their general practitioners through reforms such as the introduction of fund-holder groups, the introduction of a Charter of Rights endowing patients with the sense they had a right to quality service and the establishment of national and local standards of service were all seen as contributing to the success. The author cited Alan Langlands, chief executive of the NHS, as indicating that the key to reducing the size of waiting lists is money. In the run up to the 1992 general election, the Conservative government knew that smaller waiting lists would be a crucial element in any election victory. Money was directed to hospitals and specialists so they could reduce waiting lists to reasonable lengths. After a 32% increase in elective-surgery workload and a 10% increase in the emergency and acute-care workload, the backlog was slashed. The stress on NHS personnel was intense however as they were obliged to work nights and weekends for several months. Another impact on health care was that once people realised that they could get good service within the NHS, demand for private care dropped. The author also referred to the widespread and profound unease about what is happening to health care and the growing perception that the goal is a privatised system. These are seen as an unexpected perceptual cost of the reforms.

"Lies, damn lies and statistics"

Shorter waiting times for hospital treatment are among the indicators quoted to support claims that the introduction of the internal market and other changes to the NHS are a success. A number of papers highlight difficulties in interpreting trends in waiting list statistics. Pope, Roberts and Black pointed to the lack of a standard nomenclature and coding system for patients awaiting surgery and the absence of a generally agreed urgency rating system (12). Without these, comparisons between consultants and hospitals are difficult to interpret.

Pope expressed concern that the limit on inpatient waiting times, introduced as part of the NHS

There were inconsistencies in the relationship between urgency rating and time on the waiting list. There was evidence that for some patients an inverse relationship existed in which more urgent cases were more likely to wait longer than less urgent cases. There were some marked differences in the size of the waiting list and the mean waiting time between consultants. Analysis of the flows onto the list and work done in one month showed that it would take a considerable time to clear some lists at present rates of activity.

Morgan attributed long waiting lists for admission and unacceptable waiting times for hospital appointments to methods of waiting list management, the level of funding of NHS hospitals and the efficiency of resource use, in the face of ever-increasing demand for hospital services¹. Movement onto and off an in-patient waiting list involves decisions made by general practitioners, hospital doctors and admissions officers. There have been few incentives to ensure that waiting lists are regularly reviewed or to 'clear' a waiting list. Attempts to improve the management of waiting lists have mainly focused on increasing administrative efficiency rather than influencing referral decisions and clinical practices more directly.

Morgan describes the additional funding which, from 1987, was provided in the NHS in successive years to address waiting list problems. A proportion of funds was earmarked for districts with the greatest waiting list problems. These financial initiatives were important locally in reducing waiting lists, although having relatively little impact on national figures. The approach of providing extra cash for districts with long waiting lists often gives little incentive to achieve a more efficient management and validation of lists and to avoid a backlog of patients requiring hospital admissions.

The other main approach has been through measures designed to increase efficiency. Many measures have been introduced by districts on a fairly ad hoc basis. Examples cited by Morgan include

- walk in clinics for medical and psychiatric patients as an alternative to presentation at an accident and emergency department.
- open access diagnostic services (X-ray, gastroscopy) to reduce waiting time
- increased responsibility of senior nurses to enable more patients to be treated
- employing locums and supernumerary registrars to enable spare beds and theatre capacity to be used
- changes in allocation of theatre time and hospital beds between specialties
- use of five day wards
- expansion of day surgery.

The National Health Service and Community Care Act 1990 introduced an internal market into the NHS. The new system of financing hospital services through contracts should provide a greater incentive for hospitals to reduce their waiting lists and achieve agreed standards, including the specified waiting times, in order to attract new contracts. However, with the exception of fund-holding GPs there is no incentive for GPs to limit their referrals to consultants, or limits on consultants' decisions to admit patients for in-patient care. Morgan concludes that in the absence of a mechanism for reconciling supply and demand, it is likely that considerable waiting times for non-emergency procedures will continue.

Under the Patients' Charter, a maximum waiting time of eighteen months has been introduced for all services⁸. The House of Commons Health Committee raised a number of questions in the case of waiting lists.

- How effective are the waiting time targets set out in the Patient's Charter?

both undesirable and unacceptable.

Waiting lists as rationing devices

Traditionally, the NHS at district level has used a number of approaches to restrict access to non-emergency services. Virtually all have been implicit rather than explicit (8). One of these is waiting lists, where access to services might be restricted through delay. A waiting list may be so long as to exclude access to specific services.

Waiting lists represent an imbalance between demands for hospital care and the supply of services, according to Morgan¹. The size of this imbalance in the UK reflects both the absence of financial barriers to health care as well as the limitations of supply arising the relatively low level of funding of the NHS.

Starting from a theoretical interpretation of the NHS waiting list as a rationing device which restricts access to treatment for certain non-urgent conditions, Goddard and Tavakoli used a queuing model to investigate the efficiency and equity implications of three theoretical regimes of waiting list management²:

- firstly, treating complainants strictly in the order that they join the queue;
- secondly, affording higher priority to the more ill and lower priority to the less ill in an attempt to achieve equality between the total level of 'suffering' experienced by all treated complainants; and
- thirdly, offering rapid treatment to as many seriously ill complainants as the system can cope with comfortably without significant queues starting to build and offering the remaining (less seriously ill) complainants a prospect of treatment which is so distant or uncertain that they are dissuaded from even joining the queue.

The authors show that in the theoretical model, the numbers seeking treatment and the average duration of wait are highest under the first of these regimes and lowest under the third. While there are strong efficiency arguments in favour of the third approach, it would give cause for concern on grounds of equity. It discriminates against complainants who are insufficiently ill to receive rapid attention but who are sufficiently ill that they would seek and obtain treatment under either of the other two regimes.

They argue against the imposition of a guaranteed maximum wait, since this would be expected to increase the demand for treatment and therefore raise the level of queuing congestion experienced by all complainants. On the other hand, the model tends to favour explicit rather than implicit rationing of entry to the queue due to the potential for efficiency gains through shorter waits for complainants whose need for treatment is most acute. The authors acknowledge that the inherent flexibility and unpredictability of the NHS makes quantification of the effects of any policy change more uncertain than what they attempted to show in the paper.

Mechanic points out that governments in all nations seek means to limit public expenditure and mandates for health services (9). Explicit approaches include fixed global budgets and limits on the benefit package and eligible providers. Rationing also occurs implicitly through cost sharing, waiting lists, and requiring professionals to work within a constrained budget. Increasingly implicit rationing has been under attack as uninformed, arbitrary and inequitable. Instead, it is argued that explicit strategies such as contracting and purchasing arrangements, rating systems that establish people's preferences and the value they place on varying medical outcomes, determinations based on quality adjusted life years, outcomes research and practice guidelines should dictate allocation decisions. Mechanic maintains, in contrast, that though some explicit controls are needed over financing and the diffusion of expensive new technologies, explicit

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10. Literature Review

Waiting lists - an international phenomenon

At any time in the past 25 years, there have been large numbers of patients awaiting in-patient admission to NHS hospitals (1). Morgan points out that the large and increasing numbers of people on waiting lists has occurred despite an increase in the total numbers of patients treated. Waiting list cases are heavily concentrated among five specialties, namely general surgery, orthopaedics, ear, nose and throat, gynaecology and ophthalmology which account for 75%. Another 18% are from oral surgery, plastic surgery and urology, while all other specialties, including cardiothoracic surgery, cardiology and neurology, radiotherapy and mental illness, comprise the other 6%. Within each specialty there is further concentration of waiting list cases among a small number of conditions. The numbers awaiting advanced or life-saving procedures is relatively small.

The data indicate that considerable numbers of people wait for hospital treatment under the NHS for unacceptably long periods of time, while there are important local variations in the length of lists and waiting times. Morgan notes that the numbers of people genuinely waiting for hospital care is likely to be considerably less than the official statistics indicate as these figures often include people who no longer require an operation or are not sufficiently fit for treatment.

There has been relatively little public pressure to reduce waiting times for fairly straightforward investigative procedures or non-urgent treatments which are seldom life-threatening. Public pressure in response to long waiting times has also been reduced by the use of the private sector which forms a growing component of health service provision.

Morgan concludes that a major factor contributing to waiting lists is the ever increasing demand for health care. This growth in demand partly reflects the increasing proportion of elderly people in the population who are the heaviest users of the health services. The changes in medicine itself, with the availability of new diagnostic and operative procedures and methods of treatment creating new needs and demands are also important.

Goddard and Tavakoli agree that waiting lists have been a pervasive feature of the British health care system since the creation of the National Health Service (NHS) in 1948 (2). Despite a progressive increase in the proportion of United Kingdom (UK) Gross National Product spent on the NHS and despite numerous initiatives aimed at tackling the waiting list problem, both the number of patients on waiting lists and the average duration of wait for certain categories of non-urgent treatment have also tended to increase during the post-war period. The creation of an internal market and the separation of the functions of health care purchasers and providers as a result of the NHS reforms of April 1991 has drawn renewed attention towards the waiting list phenomenon, and created expectations that as a by-product of market-led gains in NHS efficiency, waiting times might be expected to fall.

Hemingway and Jacobson quote waiting list statistics for England (3). There were 628,800 people on an inpatient waiting list and 4,423,000 people on a day case waiting list in England on 30 September 1994. Of these, 7% and 4% respectively had waited more than one year.

New Zealand implemented major reforms of its healthcare system in 1992, including a complete split between funding, purchasing and provision of services. Long waiting lists for elective surgery had been a nagging issue that long predated the reforms (4).

It is important that success in terms of reducing waiting times or numbers on waiting lists is not at the expense of quality of care. Potential quality indicators include:

- Readmission rates
- Unplanned overnight admission of day case
- Unplanned admission to intensive care unit
- Wound infection rates
- Pulmonary embolism rates
- Mortality rates

We recommend that such indicators be included in the monitoring of waiting lists. In addition, when indicators are being analysed, other variables such as demographics and case-mix should also be taken into account.

Finally, the trend toward consumerism in health care provision must be acknowledged and we recommend that monitoring of consumer satisfaction be done routinely.

addition in Spain, patients were identified who should have been on the waiting list but who were not.

We recommend that the way in which waiting list data are collected and the definitions used be standardised both within and between countries. It is only when this is done that valid comparisons between consultants, hospitals, regions and countries can be made.

Criticism has been voiced in the literature of the use of average waiting times, which do not accurately reflect the variability of waiting times and may conceal very long waits by some patients^{6,15}. Some studies have recommended the use of centiles rather than average measures. Data presented in centiles are easy to interpret and progress toward achieving targets is readily tracked. We recommend that this approach be adopted. Furthermore, it is important to measure waiting time in a comparable way and moves should be made to standardise this. The preferred method is retrospective.

Management issues

It is clear that in the three countries included in this report consultation between clinicians and hospital management was an essential component of the waiting list initiative. The situation in Finland was unique in that the hospital manager was also a senior clinician. Presentation of national comparative waiting list data resulted in co-operation from clinical colleagues, emphasising once more the importance of good data. Where problems persisted in one clinic, the clinician/manager did some clinic sessions himself, demonstrating that the waiting list could be reduced. The importance of motivating opinion leaders in bringing about change in professional groups is highlighted.

In Ireland, where clinical independence is safeguarded in the consultant contract, hospital managers are constrained in their dealings with clinicians. In this case, the additional resources provided by the initiative facilitated dialogue between managers and clinicians and helped gain clinician co-operation. INSALUD also recognised the importance of collaboration of all parties involved in maintaining control over waiting lists. Indications for operation were devised in collaboration with groups of medical experts from national specialty associations. At hospital level, consultants and administrators worked together to review goals. In addition to including incentives, the two pilot projects in INSALUD included sanctions.

We recommend that the central role of clinicians be formalised in the management structure of waiting list initiatives and that, if possible, consultant contracts take due cognisance of their role in managing resources. Comparative waiting list data should be made available to clinicians and managers.

Linkages

Concern has been expressed internationally that efforts to reduce in-patient waiting lists will exacerbate outpatient problems¹⁵. In all three initiatives described in this report, the importance of ensuring that improvements in the in-patient waiting times were not at the expense of outpatient lists was made explicit. Target times were set in Finland from the beginning of the initiative and additional resources made available in Ireland from 1995, the third year of the initiative. INSALUD also recognised that surveys of outpatient appointments were required and began an

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8. Discussion

There are differences in size, populations and health care systems between the three countries involved in this project, Ireland, Finland and Spain. However, all three have experienced difficulties in relation to waiting lists, with large numbers of patients awaiting treatment. There are also similarities in the specialties experiencing large waiting lists, with ophthalmology, orthopaedics, urology, ENT and gynaecology posing particular difficulties. Even though the approach to solving the problem was different in the three countries, a number of common themes emerge.

Waiting list management is not an end in itself, neither is it the solution to the health needs of the population. Rather, it should be seen as just one element of an overall strategy to achieve health gain for the population. Waiting lists need not necessarily be seen as an indicator of inadequate resources or of inadequate effort. They can be seen rather as indicators of a need for goals definition, management or communication between parties. Given available resources - which are outside the control of healthcare providers, the response of those providers must be to manage waiting lists.

Goal setting

In both Spain and Finland there was great emphasis placed on reducing waiting times. In Finland explicit targets were set for waiting times for inpatient, outpatient and general practitioner care. In the initial years in Ireland the emphasis was on reducing the numbers on the waiting lists and on providing additional procedures, over and above the baseline activity of hospitals. In latter years the emphasis has shifted to eliminating delays over one year for adults and six months for children. The Patients Charter in the UK has adopted a similar approach with a guaranteed maximum waiting time.

Waiting list theory suggests the numbers seeking treatment and the average duration of wait are highest in a regime which treats complainants strictly in the order in which they join the 'queue'². A more efficient approach is to offer higher priority to those whose need for treatment is more acute and we recommend that this approach be adopted by countries experiencing waiting list difficulties. To implement such an approach requires an explicit system of deciding priority, both within and between specialties.

Whatever approach is ultimately used, it is essential that clear goals are set which are understood by all parties involved.

Priority setting

A discussion of priority setting in the context of waiting lists is a recognition that waiting lists are a form of rationing of finite health care resources. This has not been made explicit in any of the three countries included in this report. Where rationing is implicit and maximum waiting times targets are set, a situation arises where patients of low acuity may be treated before patients with greater medical need simply because they have been waiting longer.

Initiatives in Salisbury in the UK and in New Zealand have attempted to address this issue, albeit in a limited way^{18,19}. In INSALUD, guidelines and protocols for clinical practice have been established. In Ireland surgical protocols are also being developed and implemented, particularly

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6. Outpatient Waiting List Management

Insalud

It is seen as important that improvements in in-patient waiting times do not occur at the expense of those waiting for out-patient appointments. To address this, an action plan has been devised, the goals of which are as follows:

- Decrease of average waiting time by 25%
- Decrease maximum waiting time - upper limit four months for first outpatient appointment

Return of monthly information regarding outpatients is obligatory. This includes the number waiting on the last day of each month; the length of their waiting time to date (maximum and minimum length of wait) in each specialty. These numbers are then aggregated, analysed and monitored centrally. As with surgical waiting lists, anomalies and inconsistencies were discovered in definitions, methods of registration and in waiting list management systems. Variations exist between hospitals regarding list size. Further standardisation of information is being developed. Primary care physicians are also seen as part of the process and initiatives in primary care are detailed elsewhere in this report.

South Karelia

As part of the initiative's consultative process, agreed waiting times for outpatient specialist appointments were negotiated with the hospital's consultants. It was agreed that the patient should be seen by consultant within three weeks in 75% of cases. However, it is considered that waiting time for specialist consultation is still too long (between 3-8 weeks) in some specialties, especially orthopaedics and pulmonary disease.

Ireland

Outpatient waiting lists and times were included as part of the second phase of the national initiative in Ireland which took place from 1995 onwards. Additional funding was provided and targets were set for the number of additional outpatient appointments to be met and these targets were exceeded. This initiative was designed to focus upon the specialties targeted by the inpatient initiative as well as a number of other priority areas which were identified during discussion between the Department of Health and health authorities and hospitals.

As detailed elsewhere in this report, consultation with general practitioners regarding that initiative which was undertaken by one hospital showed dissatisfaction with outpatient waiting times for certain physician specialties which was addressed by the hospital.

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5. Ongoing Management of Waiting Lists

Insalud

In the region, data is returned to the Central Authority each month showing the number of patients waiting for each procedure along with their waiting times. Improved monitoring of waiting lists and waiting times and evaluation of waiting list management have been implemented, the objective of which is to devolve responsibility and awareness from health authorities to hospital managers who are expected in turn to transmit this to surgeons. The specific objectives are to:

- Improve selection of patients from the waiting list
- Increase the proportion of planned interventions
- Improve efficiency of surgical resources
- Undertake validation of waiting lists

In order to increase standardisation, hospitals are now required to submit two different data bases by electronic transfer:

- Data set of all hospital waiting list registrations
- Patients operated and those removed from the waiting list during the period (including the reasons for their removal as this is seen as a key indicator in waiting list management)

This information is checked for consistency and validation queries are raised with the hospitals concerned where large, unexplained changes occur. Special computer programmes have been developed to enable such data examination.

A monitoring system has been devised for each hospital which has the following components:

- Hospital goals are agreed between central and regional authorities (Annual Hospital Contract)
- Establishment of monthly weighted objectives, based on waiting list structure, historical surgical activity trends, supply-demand indicators and hospital waiting list management
- Feedback systems which allow for discussion of goal attainment, resource usage, waiting list management and additional resources which may be required.

In spite of improvements in the past two years, official statistics still contain anomalies and inconsistencies. Substantial variations in methods of waiting list registration and management of waiting lists still exist. To address this, a multidisciplinary group is designing a guide for the management, monitoring and validation of waiting lists. A definition of a waiting list will be devised since variations in waiting lists are principally caused by lack of precision in this area. Scrutiny of waiting lists and stricter indications for placing patients on the list will also be addressed.

South Karelia

It is recognised in Finland that waiting list management involves priority setting, management and leadership skills. Data systems are seen as the basic tool with which to develop quality systems.. Comparative data which highlights variation is an important part of the system. Following the initiative, no further prioritisation between specialties or procedures are considered necessary. Urgent cases are treated without delay; other patients are expected to see a specialist in three weeks in the outpatient department and the maximum waiting time for elective procedures is three months.

<i>Surgery</i>	1995 waiting time days	1997 waiting time days
Ear Nose Throat	126	90
Abdominal surgery	186	155
Urology	242	50
Orthopaedics	298	174
Gynaecology (sterilisation)	106	325

No waiting list difficulties have been experienced in other specialties e.g.: minor orthopaedics; cancers; coronary bypass etc.

Ireland: The funding which was provided for the waiting list initiative provided hospital managers for the first time with a negotiating tool with which to meet hospital consultants. Given the system of reporting relationships which pertain, hospital managers felt that it would have been difficult, if not impossible to ensure the compliance of consultants without such funding.

Date	Number on Waiting List
June 1993	40,130
Dec 1993	25,373
Dec 1994	23,835
Dec 1995	28,004
Dec 1996	25,959
Sept 1997	30,453

Cost

INSALUD: Costs of hospital activity and contracting-out is shown as follows:

1996: 19.5m ECU for financing 13,461 procedures

1997: 46m ECU for financing 27,392 procedures

South Karelia: Little extra cost was incurred by undertaking the initiative in South Karelia; the exceptions to this were the purchase of ultrasound equipment and employment of an extra temporary orthopaedic surgery team for six months.

1996 and 46m. ECU in 1997 was provided for certain designated surgical procedures. Hospitals with primary responsibility for patients who exceed the specified waiting time are obliged to pay for their treatment at private clinics.

South Karelia: The hospital consultant with responsibility for the initiative presented comprehensive data analysis to his colleagues and this proved sufficient to ensure compliance with the initiative. Therefore, minimal additional expenditure was required and amounted to the cost of providing an extra team in theatre for six months. Because of the enthusiasm of those involved in the South Karelia initiative, no penalties were required; in fact two specialties surrendered beds during the consultation process giving an annual saving of approx. 2m. ECU.

Ireland: The government's Department of Health provided financial incentives which amounted to 83.75m. ECU in the period 1993-1997. At hospital level, incentives were offered to those complying with each initiative as follows:

- Purchase of endoscopic and ultrasound equipment
- Incentive payment to hospitals by re-imbursement of day-case costs
- Renovation and refurbishment of wards and departments
- Minor increases in part-time and full-time staffing levels: surgical, nursing and administration

Changes in clinical practice

Guidelines and protocols for clinical practice were established by INSALUD. Other attempts to influence clinical practice in waiting list management in INSALUD, South Karelia and Ireland included:

- Increase in day-case surgery (e.g. increased by 50% in INSALUD through incentive payment)
- Minor operations performed at primary care level
- Second opinion referral
- Triage by consultant physician prior to surgery
- Introduction/expansion of endoscopic procedures
- Training in endoscopic procedures

Operational changes

Changes which occurred at operational level within and between hospitals, although simple, were recognised as effective:

- Designation of 5-day and 7-day beds/units
- Analysis and rationalisation of theatre use
- Allocation of additional theatre time
- Altered division of labour within department

Average theatre usage in INSALUD was estimated at 65% of total available surgical time in June 1996. Rationalisation of theatre usage was a fundamental part of the waiting list initiative. Targets are now set to increase morning usage to 75% of all available time. Afternoon theatre usage is to be dedicated only to those whose waiting time is in excess of one year and funding for evening use of theatre is only provided after efficient use of morning theatre time has been achieved. Contracting-out to other public or private hospitals was part of the initiative in INSALUD and also in Finland; in the latter country, cardiac surgery was so contracted.

Measures to Reduce Surgical Waiting Lists.

3. The Initiatives.

The impetus to reduce the waiting lists and waiting times had different origins in each country.

Insalud: Central government in Spain began the waiting list initiative and the regional authority in Madrid, Insalud was responsible for the initiative described in this report. INSALUD provides health care for 40% of Spain's population.

South Karelia: The Finnish Medical Association took the initiative regarding implementation of a pilot Finnish treatment guarantee programme. A seminar was arranged by the Association after which a pilot initiative was decided. Health care organisations in both primary and secondary care were involved in the decision, as were political decision-makers. Some scepticism was experienced from both politicians and doctors about the project. This report details the initiatives taken by South Karelia region with particular reference to its implementation in one hospital from 1995-1998. The waiting list group in South Karelia took the initiative regarding validation of the waiting list and this was designed by them.

Ireland: In Ireland, it was central government administration - the Department of Health the majority of hospitals in the country which initiated the project. This initiative is also described in the pages which follow along with its implementation in a major acute hospital in the Eastern Health Board region.

Base-line data

At the beginning of the initiatives, all regions recognised the need for improvement in base-line data collection and analysis in order to examine the extent of the waiting list problem and to plan for its resolution.

Insalud: In Spain, a highly developed computerised system was already in place with each hospital sending information by electronic transfer to the central authority. The primary focus for the waiting list initiative was the standardisation of entry to the list and improvement in the data which was collected. Diverging methods of entry to the waiting lists and procedures for documenting deferrals were discovered. Because of this, the actual number of patients waiting for surgery was difficult to estimate; it was recognised that either underestimation or overestimation could exist. The reliability of information regarding those already on the lists was also in question. In response to this, waiting list registration in the region was centralised. An obligatory minimum data set for all hospital waiting list registrations was established and the delivery of information to the Central Authority was regulated.

South Karelia: In Finland also, it was recognised nationally that detailed information was required in order to establish the extent and nature of the waiting list problem and that there was a lack of reliable data. Variations between specialties or districts in the length of waiting lists could not be explained: it was noted there that there was no correlation between hospital expenditure and length of waiting lists.

Ireland: Base-line waiting list data by specialty was gathered nationally in Ireland by the Department of Health.

Validation and Prioritisation of Waiting Lists

Validation and prioritisation of the waiting lists received attention as part of each initiative. As can be seen below however, validation of the lists can have unforeseen consequences:

Insalud: Hospitals were required to improve the quality of their data. Waiting lists were reviewed by the hospitals' Admissions Department to ensure they were up to date. As a result of the

Measures to Reduce Surgical Waiting Lists.

2. Healthcare Systems, Contractual Arrangements and Private Practice

INSALUD, Spain

There are 17 regions in Spain, 7 have decentralised health services, INSALUD represents central government. Universal coverage is extended to the population through seven regional health authorities. Individuals select a general practitioner who is linked to an identified group of medical specialists for specialty referral. Almost all doctors practice in Social Security facilities highly centralised (national system of hospitals and clinics).

Contracting and accountability: Hospital consultants have autonomy according to their contract. Within hospitals there is a clinical director who can influence clinical decisions. Co-operation with initiatives is reliant on the goodwill of those involved.

The extent of private healthcare: In addition to the Social Security system, a private sector insurance system has emerged to which individuals may contribute in addition to Social Security payments. The extent of private hospital provision is variable across the regions; many of these facilities are contracted by government for use by public sector patients. Primary care physicians are paid by a combination of salary/capitation while hospital physicians are paid by salary. For this latter group, salary levels vary according to the consultant's time commitment to the hospital, years of service etc.

SOUTH KARELIA

The Finnish healthcare system is primarily based on public funding. It consists of three levels of care: primary (243); central hospital (17) and university hospital (5). The system is funded through state and local taxation. Users pay on average approximately 21.5% of service costs although this varies according to the service involved. Of total public healthcare expenditure, 43.2% is spent on primary care while 56.8% is spent on specialised healthcare. All money spent on secondary care is directed through local authorities and through primary care.

Contracting and accountability: The hospital in South Karelia is owned by the ten communities of the county. All doctors and other employees are directly employed by the hospital. Within the hospital, the heads of each specialty have their own budget which can be used according to their assessment of need; it can be decided by the head of specialty if work can either take place within the hospital or if it should be contracted out to private or other public hospitals. In every specialty there is one chief doctor who is responsible for patients and finance.

The extent of private healthcare: Private healthcare is delivered by part-time specialists working in private practice on an out-patient basis. There are no private hospitals in South Karelia; doctors are allowed to have private patients in the hospital as part of their salary. The number of private patients accounts for only 0.5% of the total. Approximately 5% of doctors work solely in the private sector. In primary care, two different salary systems co-exist. The first is a monthly salary and fee-for-service which operates well and does not contribute to waiting list problems. Waiting lists exist in the second payment method which is based on monthly salary only.

IRELAND

The health services in Ireland are a mixed system and include both services provided by the State and those funded through private health insurance. The great bulk of public non-capital funding (88.1%) for the Irish health services comes from the exchequer by way of general taxation. A further 9.3% comes from an ear-marked tax, known as the health contribution and other miscellaneous sources. The remainder of public funding comes from receipts under EU regulations. Generally in the health services, 70% of costs are pay and 30% are non-pay. In the three acute hospitals directly managed by the Eastern Health Board, pay accounts for 71.6% of the budget. (National figure not obtainable.) Just over 50% of public health expenditure is spent on the acute hospital sector.

Measures to Reduce Surgical Waiting Lists.

1. Introduction

At a meeting of HOPE's Sub-Committee on Co-ordinating which was held in Ireland in June 1997, it was decided that a joint project would be established involving Finland, Spain and Ireland. The purpose of the project 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 participating countries each nominated two persons from a regional health authority within their country to the project to form a Working Group. The members of the working group were:

Matti Hannuksela (Finland)
 Mary Hynes (Ireland)
 Carmen Martínez de Pancorbo (Spain)
 Juha Metso (Finland)
 Leticia Moral (Spain)
 Mary O'Connell (Ireland)

This report describes national or regional initiatives taken to reduce waiting lists in the following:

- **INSALUD, Spain:** where 80 hospitals were involved in 1996 and 1997 in a region with a population of 15 million.
- **South Karelia, Finland:** the initiative here involved one hospital in a region whose population is 131,000. The waiting list initiative began in South Karelia in October 1995.
- **Ireland:** the national initiative took place in a country of 3.5 million population and 50 acute hospitals. Waiting list initiatives began in June 1993 and have continued since on a rolling basis each year.

Although there are differences in size, populations and health care systems between Finland, Spain and Ireland, each country had experienced similar difficulties in the growth and management of its hospital waiting lists. The following table shows the similarities which existed in specialties which presented the greatest difficulties with regard to waiting lists, with ophthalmology, orthopaedics and urology presenting challenges in each country:

Specialties experiencing waiting lists			
	Finland	Spain	Ireland
Ophthalmology	x	x	x
Orthopaedics	x	x	x
Urology	x	x	x
Ear, nose and throat surgery		x	x
Gynaecology		x	x
Cardiac Surgery	x		x
Vascular Surgery		#	x

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bodies. Scoring systems are at the foundation of prioritisation and are also essential for the implementation of a booking system, they provide transparency and can assist in both the equitable and efficient management of lists.

4.6 Demand side interventions

Clinical need should be the only cause of an expressed demand. Priority scoring systems recognise this via the 'threshold' for acceptance onto the list. Regular auditing of the list and periodical reassessment of patients on the list where necessary will restrain demand to its 'true' level. For this to be effective centralised control of the waiting system is again required. Public health education also plays a significant long term role in affecting demand for healthcare through various health awareness strategies.

4.4 Selection criteria and prioritising waiting lists

It is essential that there should be some standardised method of selecting individuals onto a list to ensure equity in the public system across physicians/hospitals/regions. This again would require more centralised control while at the same time establishing a formalised method of selection onto the list. It is accepted that a degree of physician discretion should be an integral part of this system. While it is unacceptable to have someone waiting over 24 months for cardiac surgery should such an individual been on such a list in the first place? Formalised selection criteria might not have allowed this.

More critically once a patient has been accepted onto the list they should be prioritised in a formal manner and placed in the list on that basis(Shortt 1999). Queuing for healthcare is different. First come first serve should not be a basis of treatment unless we are treating like with like. Clearly we accept that those who are clear-cut emergencies should receive immediate attention. There exists however other levels of need and patients should be judged on these. Clearly clinical status would play a large part in the prioritisation process, however personal circumstances, length of time waiting to date and again some degree of physician discretion should be included. If the issue of unacceptable waiting lists is to be addressed in the long term such an approach is unavoidable. A further advantages of such a system of prioritisation is to give a level playing field to all patients regardless of their geographical location within the country.(Jackson; Doogue, and Elliott 1999;Rao and Burd 1997;Hadorn and Holmes 1997b;Hadorn and Holmes 1997a) In addition it takes pressure off individual physicians from colleagues or public representatives who may lobby on behalf of a certain individual to get priority treatment. Such pressure on a physician to favour one patient over others is an abuse and clearly inequitable if it were to have any effect on the physician's decision.

The issue of within list prioritisation has been the focus significant levels of debate in recent years, mostly focused around the experiences in New Zealand and the potential adaptation of such a system within the NHS in the UK – trials of which are currently ongoing. The analysis of waiting lists with an emphasis on maximum waiting time and numbers on the list is alone is inadequate. A priority scoring system goes far beyond by

various waiting list in the short term but can not be viewed as a long term solution. Formalised and centralised recourse allocation and prioritisation will have to become and integral part of our healthcare management system if we are to make best use of the limited funds available to us in the face of rising demand and expenditures. There is evidence that there potentially exists considerable cost saving within public healthcare systems without cutting back on service provision. These savings would stem from the application of a Total Quality Management approach to public healthcare which as well as ensuring quality of service would tackle unnecessary waste and duplication. Estimates from the manufacturing sector suggest that from 20%-40% of operating costs are directly or indirectly due to unnecessary waste (Joss R 1995). While implementing such as system would be a difficult and lengthy process and the costs of implementation would be significant, especially given the small scale of our healthcare system, we have to ask if we can afford not to in the long run. This is particularly true if we are to retain a viable public healthcare system which will be able to adequately serve the population in a responsive manner.

4. Policy instruments for dealing with waiting lists in the short and long terms

4.1 Centralised review/control and management of waiting lists

Part of the confusion when dealing with waiting lists is that there often is no formal management structure for regulating waiting lists. Individual physicians and hospitals manage their own lists and while there may be a degree of transference between physicians and hospitals it tends to be of an ad hoc nature. This is the main reason why we often do not know how many people actually on a list. There is generally no process of continual review to check if patients have moved off the list due to death, treatment in another system/region or simply no longer wishing the intervention. International data suggests that this may inflate waiting list by as much as 20%-30%. Related to this is the fact that we are generally unaware of the burden which waiting imposes on the patient in terms of health status, as well as in socio-economic and psychological terms. While in

All surgery is planned in France in a manner very like the booking system introduced in New-Zealand. A patient may have to wait a few months for surgery but they are given their surgery date immediately. This has the added benefit of reducing uncertainty and stress for the patients and their families. The French system copes with emergency surgery cases by running bed occupancy rates at around 75% so that the system runs at all times under full capacity. Thus it can manage periods of 'peak demand' without disrupting the booking system. The growth, due to technical advances, of day care surgery has been a feature of the healthcare landscape in many countries over the past 15 years. However it is certain that the dramatic expansion of day care surgery in France in particular has played a part avoiding the problem of unacceptable waiting times.

Ultimately it could be said that France has avoided waiting lists by having over capacity built into their system. They finance this through specific social security payments which are quite significant but these social security payments almost wholly finance the system.

In addition there is the method by which the French system has addressed the issue of manpower and skills availability. The necessary number of practitioners for every speciality is determined on a centralised basis by the Ministry of Health for every region and on this basis the number of students to be trained in any speciality is determined. This requires centralised planning and clearly there is a time lag. While it is less responsive than an 'open market' would be it does not suffer from the restrictive practices inherent in the Irish system.

All this being said, France does appear to have a slight emerging problem of waiting lists – mostly at the hospital level for minor complaints and investigations. As hospital care is free of charge at the point of use in France, low-income individuals have been presenting at hospitals with minor conditions rather than consulting a physician in the first instance thus skipping the 'barrier'. This is largely not a problem for surgical waiting lists. In the short term public hospitals are implementing screening and selecting priority cases of this sort only. A long term solution recently implemented has been to educate the public about the universal insurance coverage system which has recently been introduced

publicly viewed in Canada as unacceptable lengths of time on waiting lists (Doogue; Brett, and Elliott 1997). However waiting lists in Canada predate the restructuring of the healthcare system (Barer M 1998) and are accepted to be as a result of an extended and prolonged mis-match of demand and supply compounded by poor list management.

Within the Canadian system there exists considerable differences in waiting times across regions due to lack of standards governing when a patient is placed on a list, methods in which waiting times are recorded and the method by which waiting lists are managed – usually at a individual physician or hospital surgical or diagnostic department rather than at a regional level or other co-ordinating agency (Sanmartin; Shortt; Barer; Sheps; Lewis, and McDonald 2000; Turnbull; Taylor; Hsiang; Salvian; Nanji; O'Hanley; Doyle, and Fry 2000). Canadians' high approval of their healthcare system declined significantly during this period. However when we compare Irish waiting times for comparable procedures we find that even though the Canadian system perceived itself to be in crises and was rapidly losing public support their performance was significantly better than ours. For example from 1991 to 1994 the median wait for CABG in Canada was two weeks, the average was four weeks, a wait of over 6 months reported to be vary rare and there were low rates of death while on the list (Naylor; Sykora; Jaglal, and Jefferson 1995; Turnbull and others 2000). Similar concrete information for Ireland during the same period is difficult to isolate due to the fact that management of lists was not centralised. However from ongoing work being carried out in this area it is clear that the Irish system was not performing even at these levels, indeed it was not unusual for elective public patients to wait for over one year for surgery.

2.4 Waiting experience – UK

The United Kingdom has experienced considerable public discontent at the state of waiting lists within the NHS during the 1990's, (Green 1999). There was, during this time, particular concern regarding the number of people on long-term waiting lists. To address this funds were targeted at these long-term waiters and lists were shortened. However these approaches often involved minimal extra resources with only a temporary redistribution of existing resources and on their own had little long term impact. Within the surgical waiting system it was documented that adding surgeons to a hospital had a

a significant and sustained injection of well managed funds targeting both system infrastructure and staff.

Table 1
Total Health Expenditure as a % of GDP

	1960	1970	1980	1985	1990	1995	1997
Australia	4.9	5.7	7.3	7.7	8.3	8.4	8.3
Austria	4.3	5.3	7.7	6.7	7.2	8.0	7.9
Belgium	3.4	4.1	6.5	7.3	7.5	7.9	7.6
Canada	5.5	7.1	7.3	8.4	9.2	9.7	9.3
Denmark	3.6	6.1	8.7	8.2	8.2	8.0	7.7
Finland	3.9	5.7	6.5	7.3	8.0	7.6	7.3
France	4.2	5.8	7.6	8.5	8.9	9.9	9.9
Germany	4.8	6.3	8.8	9.3	8.7	10.4	10.4
Greece	2.4	3.3	3.6	4.0	4.2	5.8	7.1
Iceland	3.3	5.0	6.2	7.3	7.9	8.2	8.0
Ireland	3.8	5.3	8.7	7.9	6.7	7.0	7.0
Italy	3.6	5.2	7.0	7.1	8.1	7.7	7.6
Japan	n/a	4.4	6.4	6.7	6.0	7.2	7.3
Luxembourg	n/a	3.7	6.2	6.1	6.6	6.7	7.1
Netherlands	3.8	5.9	7.9	7.9	8.3	8.8	8.5
New Zealand	4.3	5.2	6.0	5.3	7.0	7.3	7.6
Norway	2.9	4.5	7.0	6.7	7.8	8.0	7.4
Portugal		2.8	5.8	6.3	6.5	8.2	8.2
Spain	1.5	3.7	5.6	5.6	6.9	7.3	7.4
Sweden	4.7	7.1	9.4	9.0	8.8	8.5	8.6
Switzerland	3.1	4.9	6.9	7.7	8.3	9.6	10.2
Turkey	n/a	2.4	3.3	2.2	3.6	3.3	n/a
United Kingdom	3.9	4.5	5.6	5.9	6.0	6.9	6.7
United States	5.2	7.3	9.1	10.6	12.6	14.1	14.0
OECD Average	3.9	5.1	6.9	7.1	7.6	8.1	8.3

2.2 Report methodology

Public healthcare waiting lists are generally of internal interest to country/region. International data for waiting time for general procedures is not routinely recorded and published internationally, even by the World Health Organisation as part of their World Health Reports, (WHO 2000). However certain countries have been very active on a

of resources going to medical care such that not all care which is expected to be provided actually is provided. Fiscal scarcity within a system is not the sole cause of waiting lists. There may also be a persistent underlying scarcity of other resources such as facilities and staff. While shortages of facilities and equipment can be addressed through capital investment within a system, shortages of staff may be due to either unfavourable pay and working conditions, as we have recently seen in the case of nurses and junior doctors both in Ireland and the UK, or due to restrictive entry into the medical professions. While there is clearly a requirement to regulate medical practitioners ultimately such restrictive access is a determinant of high consultant costs.

In recent years waiting lists have become part of the landscape in the Irish public healthcare system, most notably in the area of cardiac surgery. There can be no question that, as a procedure, coronary artery bypass grafting (CABG) is highly beneficial, post surgery a return to a normal quality of life can be expected, without surgery quality of life generally continues to deteriorate and quantity of life is much reduced. A basic tenant to distributive justice is equal access for all or access independent of income. Having a private healthcare system in conjunction with a public healthcare system is natural as it gives further choice to those willing and able to pay. There is no evidence however that the quality and professionalism of medical care is in any significant way different across the two systems and typically we find many professionals working in both systems. Private healthcare can provide more 'hotel comforts' and offer a wider range of elective procedures such as certain forms of cosmetic surgery which would not reasonably be expected to be available from public funds. It can also allow consumers to avoid any waiting costs that they may experience in the public healthcare system. When waiting times in the public system are at clinically acceptable levels there is no significant inequity in this. However when waiting times are so great in the public system that individuals routinely deteriorate while waiting until they reach some emergency priority status or actually die while waiting then there is clearly inequity in the system. This is even before taking into consideration the psychological impact on the individual and their families of waiting for long periods for important interventions while facing an uncertain future.

Lengthy waiting lists do not reduce the actual cost of performing the procedure. Rather they result in the inefficient delivery of healthcare. Data from study of surgical centres in Canada reported only 51% of by-pass surgery as being elective. The remainder of the surgery was on patients who were deemed as being too ill to be discharged from hospital without surgery, (Barer M 1998). Current research being undertaken in Ireland shows a similar situation. A significant number of non-emergency patients remain in hospital until they undergo surgery. They have been told that if they return home there will be put on a long public waiting list, however if they remain in as an in-patient they will have a better chance of getting surgery sooner. What is of importance here is that these patients, while being priority cases, are not strictly emergencies. If they could be assured that they would be operated on in a timely fashion if they returned home and went on the normal elective list there would be a significant freeing up of resources. The fact that many these people have been on the elective waiting list prior to hospitalisation only further illustrates the inefficiency of having long waiting list for such procedures.

Often when we consider waiting in the context of public healthcare we tend to concentrate on waiting lists for elective surgeries such as coronary by-pass surgery, cataract surgery and hip replacement. This is typically due to the fact that these forms of surgery have a high public profile due to their emotional context and high impact on an individual's quality of life. Waiting lists however are not confined to surgical areas. Individuals in the Irish public healthcare system can and regularly do wait significant periods of time for routine specialist consultations and diagnostic procedures. Thus an individual's waiting experience can begin well before they are placed on a 'formal' waiting list. In addition there are areas such as organ transplant, which by its nature of uncertain supply, typically has associated with it a degree of waiting time – the organisation and management of such waiting lists is largely beyond the scope of this report though certain issues relating to list management are common across all waiting lists.

This report concentrates largely on waiting time for elective surgery as this is the most widely documented internationally. It first describes the situation facing developed countries and documents some specific experiences from selected countries where information has been available (Section 2). The report then briefly considers the possible

on the outside by spending unduly long periods in in-patient care—evidenced statistically in the high number of bed-days used by Irish patients in comparison to their counterparts internationally.

Primary care

The *Report of the review group on the waiting list initiative*, (Executive summary, Appendix 3), said that “a satisfactory response [to waiting lists] must reach beyond the acute hospital services alone” and further called for an “improved flow of information between primary and hospital care regarding the status of patients on waiting lists”.

Apart from inevitable cost implications, the development and expansion of healthcare at the primary and community level, in line with our European neighbours, and a greater integration of primary and secondary care, will have significant follow-on improvements for more rapid processing of patients through the acute hospital system and therefore for the length of our waiting lists..

Conclusions

1. The lack of centrally collated data on waiting lists within the European Union points to a significant gap within our knowledge. It points to an urgent need for statistical research within this area. The generation of data-based knowledge will assist in moving towards basic agreed standards in care across Europe while respecting our rights as individual countries to provide a system of healthcare most appropriate to local needs, cultures and traditions.
2. As noted by the *Report of the review group on the waiting list initiative* (p.i, Executive summary, Appendix 3), “there are no simple short term solutions which, on their own, will have a significant impact”. In addition to the range of solutions outlined in the attached documents, as derived from international research and experience, we need to recognise that we will not solve the problem of waiting lists in Ireland until we accept, as legislators and as citizens, that our two-tier system of healthcare is a significant part of the problem. Built into its basic structure is an

Public hospitals are allowed to take private patients up to certain limits. Even if public beds are closed, these limits are not affected. As public hospitals operate on fixed budgets, private patients enhance hospital earnings and thus under the current system they are unlikely to wish to reduce their number in favour of their public counterparts.

We cannot, however, lay blame on the private patient. This is quite simply how the current system works. It is the structure which needs to be tackled to enable equitable and timely access to necessary care as need dictates, irrespective of patient status.

The public/private mix—who benefits?

Both the attached document, *Waiting lists for healthcare in developed countries—Initiatives for long term management*) and a 1998 report prepared for Health Canada suggest that “greater access to private care appears to be generally associated with longer public sector queues—particularly where physicians operate in both sectors”⁶, as in the UK and particularly in Ireland.

We are fortunate in Ireland that the professionalism of our consultants has moderated the negative effects of the structure of our health system.

Over 80% of consultants in this country are engaged in both public and private practice. While contracts in the public service engage consultants for 33 hours per week, there is no limit on the time that can be devoted to private practice.

There is in effect an inherent incentive within the system for consultants to create waiting lists for treatment. Although everybody in this country has a public entitlement to care, those with health insurance will use it to pay for treatment, while those who do not will (if they can access the necessary moneys) either pay up front or take out health insurance in anticipation of future need. Such queue-jumping is now an integral part of the Irish healthcare system.

6 Available on the internet at: www.hc-sc.gc.ca/iacb-dgiac/nhrdp/wlsum5.htm

With £12 million invested in 1996, waiting lists fell again to 25,969 only to rise to 32,206 by December 1997, despite the £8 million invested that year. With another £32 million shared between 1998 and 1999, the numbers waiting had further climbed to 36,855 by December 1999—highlighting the very temporary nature of improvements effected.

So it's not simply a question of money?

It is interesting to compare and contrast, in the attached report from the *Irish Medical Times* of December 1998 (Appendix 2) concerning “Health services in each of the EU member states”, not only differences in number of inhabitants per doctor, number of hospital beds per 1,000 inhabitants and total expenditure on health as a percentage of GDP across the EU, but also how health services are funded in these countries; in short to see whether we can draw correlations between infrastructural provisions and waiting lists⁴.

We do not have adequate information to draw definitive conclusions on the relationship of health system structures to waiting lists. However, the apparent absence of waiting lists particularly in France and Germany, suggests that the equality of access underpinned by the social insurance model found in these countries may well contribute to more immediate care for everyone. In addition, the relatively high levels of per-capita spending on health in each of these countries must also be counted as hugely significant.

What about countries with waiting lists?

The attached report, *Waiting lists for healthcare in developed countries—initiatives for long term management*, takes three countries, namely the UK, New Zealand and Canada where waiting lists are or have been problematic

In Canada, waiting lists have resulted from a range of factors—from financial cutbacks to uneven levels of access to care across the country and poor list management.

⁴ See also Appendices 5 and 5a for OECD health system structure comparatives and analysis of Irish system within that perspective.

So numbers haven't actually come down under the Initiative?

Irish waiting list figures suggest that investing additional specifically targeted resources and providing incentive payments to hospitals, even with enhanced list management, reviews and prioritisation, will at best arrest the rate of growth or provide periodic drops in the total numbers waiting.

Despite a total of £124.57 million invested in the Waiting List Initiative since its inception in 1993 (see *table 1.1* below), extraordinarily long waiting periods still persist.

Without structural reform of our two-tier system of access to health services with its in-built system incentives against rapid patient throughput (such as fear of going over fixed hospital budget or greater financial incentives to treat private patients) we will not solve the problem of waiting lists³.

Year	Amount	March	June	September	December
1993	IR£20 m	39,423	40,130	25,165	25,373
1994	IR£10 m	27,576	24,778	27,633	23,772
1995	IR£ 8 m	27,475	27,696	27,004	27,752
1996	IR£12 m	28,865	30,447	31,519	25,959
1997	IR£ 8 m	29,069	30,453	32,252	32,206
1998	IR£12 m	33,847	34,331	35,405	36,883
1999	IR£20 m	34,996	33,924	33,555	36,855
2000	IR£34.57 m	34,370	31,851		
TOTAL IR£124.57 m					

Table 1.1

Waiting lists numbers and investment under the Waiting List Initiative

³ The private patient population in Spain and Finland is negligible in comparison to Ireland—e.g. in Finland, only 0.5% of patients are private.

What's the biggest problem with waiting lists?

Indisputably, the greatest problem with waiting lists in Ireland is the actual length of time spent waiting.

If we look at the examples outlined in the HOPE report on *Measures to reduce surgical waiting lists* (Appendix 1), in which regional initiatives in Finland and Spain and the national Waiting List Initiative in Ireland were examined, we see just how unfavourably the Irish situation compares. (Figures in this report were for the 1996-97 period).

(i) Finland

In 1997, the South Karelia region in Finland experienced waiting times ranging from 90 days for ENT procedures to 325 days for gynaecology (sterilisation). There was no waiting period incurred for cancer surgery, coronary bypass or minor orthopaedics (Appendix 1, *HOPE Report, section 4*).

(ii) Spain

In the Spanish study, covering a region of 15 million people which included the city of Madrid, 148,224 people were on waiting lists in December 1997. Of that number, only 826 waited more than 9 months (0.005%) while the average wait was just 98 days.

Those figures compared to 21,525 people waiting more than one year out of a total of 168,265 on waiting lists just 18 months previously (see p.8, Appendix 1). Average wait times for the earlier period had been 217 days.

These reductions were achieved by a number of measures including standardisation of waiting list registration systems, standardised criteria for placement of patients on waiting lists, prioritisation of list and selection of patients from lists and incentive payments to hospitals for day cases.

What's the point of waiting lists?

Waiting lists are used to ration health services, although supposedly only for certain non-urgent conditions. What happens in fact is that waiting lists are also used to apportion treatment to seriously ill patients—cancer and heart surgery, two of the biggest killers in Ireland and the UK included. The waiting list may ultimately be so long as to actively exclude access to specific services, because the patient dies or otherwise removes him/herself from the list, opting out of treatment altogether or seeking other avenues within the private sector.

Everyone has a statutory entitlement to free public hospital care in Ireland. Yet this entitlement cannot be met and is not met by public hospital services, as evidenced in particular by the existence of waiting lists.

We have reached the extraordinary point where 45% of our population is covered by private health insurance—quite simply to ensure (according to recently published ESRI research) that quality care can be accessed when needed.

How do we compare internationally?

We experienced significant difficulty in drawing a comparative picture of waiting lists across Europe because of the lack of available information. According to the office of the European Commission in Luxembourg, comparative data on waiting lists simply does not exist. We were therefore prevented from drawing comprehensively on the resources of knowledge and experience available within the Union.

In addition to Ireland and the UK, where the problems of waiting lists are most acute, we know, for example, that the Netherlands, Spain, Sweden, Finland and Denmark have each endured differing degrees of waiting list difficulties. Often, it is a regional and/or sectional problem—as opposed to a national problem across all areas in Ireland. Outside the EU, problems with waiting lists in Canada and New Zealand are often cited.

However, we also know that waiting lists are not an inevitable result of necessary rationing and prioritisation in public health care systems—as evidenced by the examples

