Swedish Waiting Times for Health Care in an International Perspective
Forewords

The Swedish healthcare system, which is financed primarily by taxes, covers all citizens and registered residents. The system consumes almost one-tenth of society's resources. Thus, efficient resource utilisation and satisfactory outcomes are of vital importance for both patients and the population as a whole.

The Swedish Association of Local Authorities and Regions (SALAR) has followed the efficiency and quality of the healthcare system for a number of years by means of the Open Comparisons that it publishes in collaboration with the Swedish National Board of Health and Welfare. Two additional reports published in 2005 and 2008 have also made international comparisons and found that the medical results of Swedish health care stack up well against other countries and do so at modest costs. Due to difficulties in obtaining suitable data, however, the comparisons have not looked at the issue of availability (waiting times). Thus, this third international comparison focuses exclusively on waiting times and addresses the question of whether various countries can be measured against each other in that respect.

Nina Viberg of SALAR and Karolinska Institutet wrote the report and conducted most of the research. Roger Molin of SALAR, as well as Birger Forsberg of the Stockholm County Council and Karolinska Institutet, contributed their specialist knowledge, reviewed drafts of the report and assisted in its design. The language skills of a number of helpful SALAR employees and frequent interaction with members of the Availability Team simplified the effort.

Stockholm, May 2011

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Summary and Conclusions

A lively discussion is under way in Sweden about waiting times. Both public officials and the media have assumed that availability is poor (waiting times are long) both in absolute terms and in comparison with other countries. Ever since the first care waiting time guarantee was adopted in 1992, a number of attempts have been made to reduce waiting times by means of national healthcare policy. However, only recently has there been a clear improvement in connection with the introduction of a financial stimulus reform entitled Kömiljarden (waiting list billion). Nine out of ten patients now receive care within the upper limits set by the care guarantee, and availability is approaching the national targets.

This is the third international comparison published by SALAR. The two previous reports focused on medical outcomes and on costs. Sweden performed well in both cases, generating good results at modest costs. While the previous comparisons did not examine availability (waiting times) due to difficulties in collecting suitable data, this appears to be the area in which Sweden is most vulnerable to criticism.

International studies that compare waiting times and provide evidence of how well Sweden is doing are few and far between. A handful of studies based on surveys of patients, hospitals or the general public have included Sweden. They have found that waiting times in Sweden are relatively long. The purpose of the present report on availability and waiting times is to shed light on this important question.

The primary objective of this study was to determine whether waiting times for health care can be compared across various countries and whether public national statistics support the assertion that Sweden has relatively long waiting times. A secondary objective was to establish which countries measure waiting times, the methods they use and the kinds of national care guarantees they offer.

The report is based chiefly on online sources, studies of the literature and informal interviews with key persons.

The study found that 16 (Sweden, Denmark, Finland, Norway, England, Scotland, Wales, Northern Ireland, Ireland, Portugal, Spain, the Netherlands, Canada, New Zealand, Australia and to some extent the United States) of the 23 countries examined have some form of published waiting time follow-up at the national level and many of them have care guarantees. There are many ways of measuring waiting times. Among the differences are whether the "ongoing" or "completed" waiting period is measured, what kind of care the patient is waiting for, what parameters are used and where in the patient journey the measurement begins.
That a country does not report waiting times at the national level does not necessarily mean that it does not have an availability problem. Italy and Austria are trying to improve transparency, and reports from Greece indicate that informal payment is used to bypass the ordinary queues. Inequitable waiting times due to place of residence or type of insurance are widely discussed in Germany and France, whereas the main issue in the United States is how to provide care for the millions of uninsured people.

Given all the methodological differences among the various countries, waiting times cannot be compared without stating certain reservations. Nevertheless, the compilation of selected data that is presented in this report does not suggest, as had been previously alleged, that the Swedish healthcare system offers significantly poorer availability than other countries.

The report concludes that many countries measure waiting times and have some type of national care guarantee, suggesting that Sweden is far from the only one to regard healthcare availability as a problem. There is a great deal of variation with respect to that which is measured (ongoing or completed waits, etc.), the parameters employed (such as the median or mean number of days), where in the patient journey measurement begins, and the types of patients and healthcare units that the data concern.

Owing to methodological differences, the report concludes that the national waiting time data published so far can be used to only a very limited extent for comparing the availability of health care among the various countries. The national statistics that have been presented to this point do not support the claim that Sweden has significantly longer waiting times than other countries. On the contrary, the data suggest that the Swedish healthcare system does not differ noticeably from many others in terms of availability.

The study contributes to greater understanding of whether and how waiting times are monitored, how they are reported and the extent to which they are regarded as a problem in the various countries under consideration.
Objective

The primary objective of this study was to determine whether waiting times for health care can be compared across various countries and whether public national statistics support the assertion that Sweden has relatively long waiting times. A secondary objective was to establish which countries measure waiting times, the methods they use and the kinds of national care guarantees they offer.
Introduction

The issue of waiting times in Sweden

This is the third international healthcare comparison that SALAR has published. The first report, which appeared in 2005, concluded that the Swedish system stacks up well against other countries when it comes to availability, quality and outcomes. Costs were also shown to be modest, i.e., resources were used efficiently. [1] The comparison was repeated in 2008, this time using a composite index with respect to results, costs and efficiency. Once more the conclusion was that Swedish health care performs well from an international perspective. While the first two reports did not examine availability (waiting times), they indicated that Sweden is most vulnerable to criticism in that area. Not that care is unavailable by any means – on the contrary, access and results are good – but too many patients have to wait for doctor's appointments and elective care longer than they should. [2] Thus, the present international comparison concerns waiting times and addresses the question of whether the availability of different healthcare systems can be compared, as well as whether published national statistics support the claim that Sweden performs poorly in this respect.

A lively discussion is under way in Sweden about waiting times. Both public officials and the media have assumed that availability is poor (waiting times are long) both in absolute terms and in comparison with other countries. Ever since the first care guarantee was adopted in 1992, a number of attempts have been made to reduce waiting times by means of national healthcare policy. However, only recently has there been a clear improvement in connection with the introduction of a financial stimulus reform entitled Kömiljarden (waiting list billion). Nine out of ten patients now receive care within the upper limits set by the care guarantee, and availability is approaching the national targets. [3-5]

Only a limited number of international waiting time comparisons are available. In the absence of more recent studies, a 2003 article by Sicilian and Hurst entitled Explaining Waiting Times Variations for Elective Surgery across OECD Countries is often cited. The article concluded that waiting times were a problem in Italy, Ireland, England, the Netherlands, Australia, Canada, the Great Britain, Sweden, New Zealand, Norway, Spain, Denmark and Finland. According to the article, Austria, Belgium, Switzerland, Japan, Germany, Luxembourg and the United States did not report waiting time statistics because they did not experience any problems. [6] A more recent report entitled Euro Health Consumer Index 2009 by Health Consumer Powerhouse ranked European healthcare systems from the consumer's point of view. Sweden scored highest when it came to medical results and "range and reach of services provided" but was in ninth place overall due to the issue of waiting times. Albania, Belgium, Germany and
Switzerland had the best scores in terms of waiting times. [7] (See Appendix 3 for additional information about these and other international studies.)

What affects waiting times as a phenomenon?

Although this report does not explore the causes of long waiting times, several factors that affect them as a phenomenon need to be mentioned. The percentage of patients who can be placed on a waiting list is determined by the number who have access to health care and the indication for which the care provider performs the procedure in question. For instance, the lower limit for the degree of visual impairment that requires cataract surgery will affect the number of patients whom a particular care provider places on the waiting list. Thus, the fact that a care provider has a shorter queue for cataract surgery than another one may be due to the fact that its waiting list threshold is higher. [8] The speed at which patients are taken off the waiting list is affected by the frequency with which surgery is performed. If surgery is performed infrequently, waiting times may be long even though the queue is short. Indications for, and frequency of, surgery may vary both within and among different countries (see Figures 1 and 2). An effort is under way in Sweden to develop national decision-making routines that will harmonise medical indications and ensure uniform care throughout the country. [9]

The existence of queues is often explained in terms of imbalances between healthcare supply and demand. If demand exceeds supply, a queue forms. [10, 11] In Sweden, the queues have held constant for several years instead of growing. [3] According to healthcare logistics research, the reason is not that demand consistently exceeds supply (capacity) but that variation in capacity does not adapt to the variation in demand. Excess demand during a certain period of time generates queues, whereas temporary excess capacity cannot be saved up for future use. The queue can be temporarily eliminated by means of isolated measures but soon returns. [12]

Under certain circumstances, queues may reflect that full capacity utilisation and that capacity cannot be further increased even though additional patients are in need of care. Queues may also form due to the presence of a bottleneck; in such cases, reallocation of existing resources rather than the addition of new ones may be the solution. [12] The total absence of queues may indicate that resources are being wasted.

One reason that supply does not increase despite higher demand is that the care provider may lack the proper incentive. Financial incentives, such as compensation of the care provider per unit produced, can be created to address that problem. The more patients, the higher the care provider's revenue. [6]

Sweden's effort to shorten its queues has been assisted by the Kömiljarden (waiting list billion) financial stimulus and has been based on the Vårdgarantihjulet (care guarantee wheel), which describes the interplay of parallel measures in multiple spheres of activity, including medical indications, process development and handling of referrals. [3]
Healthcare systems

Waiting times cannot be seen simply as an isolated phenomenon, but must be examined from the perspective of the entire healthcare system. OECD healthcare systems may be broken down into national (Beveridge-type), social insurance (Bismarck-type) and private. [14] The determination of which patients have access to care and thus can be placed on a waiting list reflects a number of factors whose relationship varies among the different types of systems. National systems claim to provide universal coverage, but social insurance systems do so as well nowadays. The line between these two system types is also being blurred as national systems open the door to private insurance and care providers while offering greater freedom of choice to patients. [15, 16] National systems are generally regarded as being most prone to have problems with queues. One reason may be that in national systems providers are often paid by means of salaries or...
fixed compensation whereas they in social insurance systems often are remunerated per care event. [6]

Private systems, represented here by the United States, do not guarantee universal coverage. In 2009, 15.4 per cent of the U.S. population (46.3 million people) were uninsured and had only limited access to health care. [16, 17] The fact that these people are not included in waiting time statistics may be one reason that the United States is often reported to have short queues for elective care. [16]

The member states of the World Health Organisation agreed in 2005 to develop their health financing systems to the point that universal coverage would be guaranteed. The 2010 World Health Report Health Systems Financing: the Path to Universal Coverage focuses on ways of modifying the systems in order to reach the target. Figure 3 describes three different dimensions to consider when striving for the kind of universal coverage that WHO envisions: 1. the percentage of the population that is covered by (has access to) the healthcare system; 2. the type of care that is included; 3. the percentage that patients must pay out of their own pocket (co-payments) [18]

Figure 3: Three different dimensions to consider when striving for universal coverage: 1. the percentage of the population that is covered by (has access to) the healthcare system; 2. the type of care that is included; 3. the percentage that patients must pay out of their own pocket (co-payments) [18]

Busse et al include these dimensions among six “access hurdles.” The other three are geographical barriers, organisational barriers (such as waiting times) and utilisation of accessible services (such as socioeconomic, ethnic and gender-related differences in the use of health care). [19]

Of decisive importance in comparing waiting times among different countries is to consider patient journey and the structure of the healthcare system. In some countries, general practitioners serve a gatekeeping function such that patients must obtain a referral before they can see a specialist. In other countries, no such referral is needed. The kinds of services offered by primary and specialised care also vary. Furthermore, access and availability may differ from region to region even though those data do not show up in the national statistics.
Methodology

The study included the EU 15 countries (the Member States before 2004): Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom (broken down into England, Scotland, Wales and Northern Ireland), as well as Australia, Canada, New Zealand and the United States. These OECD countries were chosen because their living standard and health status are comparable to Sweden.

The first phase of the study involved a detailed review of the literature. Swedish and foreign literature and public documents were examined in order to better understand the phenomenon of waiting times, as well as the significance of accessibility and availability in various types of healthcare systems.

Google, Google Scholar and PubMed were then used to perform an extensive online search. Typical search terms were "waiting time" and "waiting list" combined with for example "health care" and "England". The websites of international organisations and national governments, primarily ministries of health, were perused. One source that turned out to provide a useful indication of whether a country was experiencing problems with waiting times was the European Health Observatory on Health Systems and Policies series entitled Health Systems in Transition. [20]

Informal interviews were conducted with key people at SALAR and elsewhere. Key people in various countries were contacted by e-mail and/or phone when detailed explanations or additional information were needed beyond that which was available online.

In order to gain an overview of the comparability of different waiting time statistics, a survey was conducted concerning whether, how and the extent to which the various countries measure waiting times, the parameters they use and the point in the patient journey at which they start.

The study concluded with a survey of the countries that have some type of national care guarantee and the degree to which it is fulfilled.
Monitoring waiting times

It became obvious at an early stage of the process that a wealth of waiting time statistics is available from official national sources. Many countries monitor waiting times, but they generally have their own particular way of doing so. The first difference involves whether actual waiting times (completed waits) are measured, i.e., a retrospective look at patients who have already received care. A country can also report on the patients who are presently waiting (ongoing waits). Some countries present statistics on "expected waiting time" for new patients. Given its predictive character, expected waiting time is not included in this report.

The next question is where in the patient journey waiting times are monitored. Some countries measure telephone availability and waiting times to primary care appointments. The most common approach is to concentrate on specialist appointments, examinations, diagnoses and/or treatment. The types of care for which waiting times are measured also vary. Some countries summarise the results by specialty, such as gynaecology, orthopaedics or all elective surgery. Others take the next step and look at specific interventions or operations, such as cataract surgery.

Some countries link waiting time data to patient registers so that they can monitor at the individual level. Countries vary when it comes to the kinds of health care facilities (private or public, hospitals or health centres, etc.) for which they measure waiting times. Appendix 1 shows waiting time monitoring by country.

The following presentation excludes waiting times for examinations, diagnosis and emergency care, given that no country limits its data to those areas. Primary and specialist appointments are not included either because countries differ in terms of patient journey. The focus is on elective surgery, for which comparisons are deemed to be more reliable.

Sixteen of the 23 countries monitor waiting times at the national level and publish the results. Table I shows the countries that publish data on waiting times for elective surgery and the level of detail at which they do so. The number of specialties and specific types of surgery that are monitored vary from country to country. Whether every operation is actually included in "elective surgery" is not always clear. Sometimes what is meant is "all elective surgery for which waiting times have been measured". England presents waiting time statistics that have been collected in two different ways: Referral to Treatment Times (RTT) and Hospital Episode Statistics (HES). For additional information, refer to Appendix 1.
Waiting times for: Elective surgery By specialty Specific types of operations

<table>
<thead>
<tr>
<th>Country</th>
<th>Sweden</th>
<th>Denmark</th>
<th>Finland</th>
<th>Norway</th>
<th>England</th>
<th>Scotland</th>
<th>Wales</th>
<th>Northern Ireland</th>
<th>Ireland</th>
<th>Portugal</th>
<th>Spain</th>
<th>Netherlands</th>
<th>Canada</th>
<th>New Zealand</th>
<th>Austria</th>
<th>USA</th>
<th>Italia</th>
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<tbody>
<tr>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X (RTT &amp; HES)</td>
<td>X (RTT &amp; HES)</td>
<td>X (HES)</td>
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<table>
<thead>
<tr>
<th>Country</th>
<th>Austria</th>
<th>Italia</th>
<th>Greece</th>
<th>France</th>
<th>Germany</th>
<th>Belgium</th>
<th>Luxembourg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Legislative amendments in process</td>
<td>Incomplete national monitoring (but striving for it)</td>
<td>No national monitoring</td>
<td>No national monitoring</td>
<td>No national monitoring</td>
<td>No national monitoring</td>
<td>No national monitoring</td>
</tr>
</tbody>
</table>

Table 1. Countries that publish national waiting time data for elective surgery and the level at which they do so.

*Unconfirmed

²Presents national statistics for: “Timeliness of primary, emergency, and hospital care: getting care for illness or injury as soon as wanted. In addition, two supporting measures are presented: Emergency department waiting times, and timeliness of cardiac reperfusion for heart attack patients” [21]

Some countries without national monitoring still measure waiting times at the regional level. For instance, Italy's goal is that all regions eventually will report waiting times online. German hospitals measure waiting times, but the country does not perceive any problems at the national level and the debate has revolved around the fact that people who are privately insured have faster access to health care. [22-24] Austrian researchers have also found that privately insured patients have faster access and have refuted the notion that the country has no waiting times at all. In a report from the Institute for Advanced Studies (IHS) in Vienna the lack of transparency with respect to waiting times has been harshly criticised. [25] A statutory requirement for public reporting of waiting times at the provincial level has been proposed in Austria. [26]

France's lack of national monitoring is often cited as evidence that it has no waiting time problems. However, the large regional differences in terms of services provided and
number of doctors have led to inequities when it comes to availability. [27] Greece suffers from long waiting times, and informal payments to “jump the queue” are common. [28] In the United States, access to care varies according to socioeconomic status and geographic area. A significant percentage of the population is uninsured, which means that they have limited access to health care. [29] For additional information about the individual countries, see Appendix 1.
The next consideration is what parameters are used to report waiting times. Among the possibilities are mean, median, 90th percentile, 95th percentile, number of patients waiting, number of patients waiting per inhabitant, and number of patients waiting within a certain time interval. The parameters used by each country are shown in Table 2 for completed waits and Table 3 for ongoing waits.

<table>
<thead>
<tr>
<th>Completed waits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is reported?</strong></td>
</tr>
<tr>
<td>Sweden</td>
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<td>Denmark</td>
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<td>Finland</td>
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<td>Norway</td>
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<td>England</td>
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<td>Scotland</td>
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<td>Wales</td>
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<td>Northern Ireland</td>
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<td>Ireland</td>
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<td>Portugal</td>
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<td>Spain</td>
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<tr>
<td>Canada</td>
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<tr>
<td>New Zealand</td>
</tr>
<tr>
<td>Australia</td>
</tr>
<tr>
<td>Netherlands</td>
</tr>
<tr>
<td>*no external reporting</td>
</tr>
<tr>
<td>&lt;sup&gt;a&lt;/sup&gt; HES, &lt;sup&gt;b&lt;/sup&gt; RTT</td>
</tr>
</tbody>
</table>

*Table 2. Waiting time parameters for completed waits*
Once an overview has been obtained of the services for which different countries measure waiting times and the parameters used, a decisive question arises: where in the patient journey do the measurements begin? The arrows in Figure 4 show the points at which various countries begin to measure waiting times for contact, primary care appointments, specialist care appointments and treatment. Figure 5 focuses specifically on treatment in order to determine the countries that may be suitable objects for waiting time comparisons.

### Table 3 Waiting time parameters for ongoing waits

<table>
<thead>
<tr>
<th></th>
<th>Number of patients waiting</th>
<th>Number of patients waiting in time intervals</th>
<th>Number of patients waiting per inhabitant</th>
<th>Median (mean) waiting time</th>
<th>Fulfilment of guarantees /maximum waiting times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden</td>
<td>X</td>
<td>X*</td>
<td>X*</td>
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<td>Denmark</td>
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<td>Norway</td>
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<tr>
<td>England</td>
<td>X</td>
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<tr>
<td>Scotland</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Wales</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Northern Ireland</td>
<td>X**</td>
<td>X</td>
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<tr>
<td>Ireland</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Portugal</td>
<td>X</td>
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<tr>
<td>Spain</td>
<td>X</td>
<td>X</td>
<td>(X)</td>
<td>X</td>
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<td>Canada</td>
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<td>New Zealand</td>
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<td>Australia</td>
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<tr>
<td>Netherlands</td>
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</table>

* HES
* no external reporting
**ongoing waits and completed waits
Figure 4. At what point in the patient journey do countries begin measuring waiting times? Examples of starting points for measuring waiting times (completed waits) for contact, primary care appointments, specialist care appointments and treatment.
Figure 5. Where does a country begin measuring waiting times for treatment? Starting points for measuring waiting times (completed waits) for treatment.
Waiting time comparisons

The above review of the methods employed by various countries makes it clear that of those that, like Sweden, begin measuring waiting time from the decision-to-treat date, only Canada and England use the median, which is the most comparable parameter. Thus, a correct comparison of published waiting time statistics is not possible. Nevertheless, the following discussion presents published waiting times for elective surgery that may serve as an overview of the situation in various countries with respect to the point in the patient journey at which measurement begins, the parameters used and whether the focus is on completed or ongoing waits.

Patient journey after the measurements begin may vary from country to country but is not further examined here. It should be kept in mind that ongoing waits generate an underestimate compared to completed waits and that mean waiting time, because it is exposed to outliers, may generate an overestimate compared to median waiting time.

In order to arrive at a more easily comparable parameter for Sweden, which reports completed waits in time intervals, the interval that contains the median has been calculated. Table 4, as well as Figures 6-8, present the overview.
Table 4. Waiting times in days to elective surgery

Countries that perform temporary measurements are also included as long as they claim to be nationwide.

<table>
<thead>
<tr>
<th>Country</th>
<th>Waiting time parameter</th>
<th>Elective surgery</th>
<th>Total hip replacement</th>
<th>Cataract</th>
<th>Comment and reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden</td>
<td>The median is within this time interval</td>
<td>31-60</td>
<td>31-60</td>
<td>31-60</td>
<td>[30]</td>
</tr>
<tr>
<td>Canada</td>
<td>Median</td>
<td>Decision to treat</td>
<td>42*</td>
<td>2*</td>
<td>178*</td>
</tr>
<tr>
<td>France</td>
<td>Median</td>
<td>Unclear</td>
<td>33*</td>
<td>66*</td>
<td>α“toutes spécialités”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>α&quot;ophthalmology&quot;</td>
<td></td>
<td>From EDPS report 2004, cited in [27]</td>
</tr>
<tr>
<td>Netherlands</td>
<td>'Mean' rounded to weeks</td>
<td>49-56 (Just over 7 weeks)</td>
<td>35-42 (Just over 5 weeks)</td>
<td>2009 [31]</td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td>Mean</td>
<td>Decision to treat</td>
<td>86 (2.85 months)</td>
<td>70 (2.35 months)</td>
<td>p&quot;ophthalmology&quot; 2009 [32]</td>
</tr>
<tr>
<td>Australia</td>
<td>Median</td>
<td>Referral received</td>
<td>34</td>
<td>100</td>
<td>84</td>
</tr>
<tr>
<td>Denmark</td>
<td>Median</td>
<td>Referral received</td>
<td>38</td>
<td>58</td>
<td>112</td>
</tr>
<tr>
<td>Norway</td>
<td>Mean</td>
<td>Referral received</td>
<td>75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scotland</td>
<td>Median</td>
<td>Referral written</td>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ireland</td>
<td>Ongoing waits</td>
<td>Median</td>
<td>Patient listed</td>
<td>75</td>
<td>90</td>
</tr>
<tr>
<td>Spain</td>
<td>Ongoing waits</td>
<td>Mean</td>
<td>Patient listed</td>
<td>61</td>
<td>86</td>
</tr>
</tbody>
</table>

*Example: The typical patient (50th percentile) waits between 42 and 178 days (2 and 88 days), depending on the province where he or she receives treatment.
Figure 6: Waiting times in days for all elective surgery
Countries that perform temporary measurements are also included as long as they claim to be nationwide. Sweden: The point in the interval at which the median (45) lies has been estimated on the assumption that waiting times are normally distributed within the interval (waiting times due to the patient's own choice have been excluded).

Figure 7: Waiting times in days for total hip replacement surgery
Countries that perform temporary measurements are also included as long as they claim to be nationwide. Sweden: The point in the interval at which the median (45) lies has been estimated on the assumption that waiting times are normally distributed within the interval (waiting times due to the patient's own choice have been excluded). Canada: The median waiting time varies from 42 to 178 days depending on the province.
Countries that perform temporary measurements are also included as long as they claim to be nationwide. Sweden: The point in the interval at which the median (31) lies has been estimated on the assumption that waiting times are normally distributed within the interval (waiting times due to the patient's choice have been excluded). Canada: The median waiting time varies from 2 to 88 days depending on the province.
Other international comparisons

Appendix 3 reviews other international studies that have concerned waiting times. None of them have exclusively relied on published national statistics. Most of them have collected data by means of surveys of the general public [39–47], hospitals [48], patient organisations [7], researchers [19] or administrative sources [7, 49]. The difficulties associated with comparing waiting times are lifted, for example that countries report them in different ways [10], define them differently [48] and measure different periods [49]. The studies that include waiting time data for Sweden suggest that it performs poorly compared with other countries – or at least that it has a problem with long waiting times. [6, 7, 39–41, 48] The perception that the Swedish patients and the general public have of waiting times seems to be particularly unfavourable. [7, 39–41, 43, 45–47]
Appendices

Appendix 1. Waiting time monitoring by country

The following review of the various countries examines whether they monitor waiting times and, if so, how they do it. The review primarily concerns the types of waiting times covered by the report and is based on information that has been published, usually online, at the national level. A country may perform other types of waiting time measurements than those presented here. If a country does not perform national monitoring, the current status of waiting times is discussed instead.

Sweden

Are waiting times monitored?
Yes, at the national level.

By whom?
SALAR coordinates the measurement of different clinics at the national level.

What is studied/what is measured? What variables are followed?
The information below is based on the official website www.vantetider.se as well as the national waiting time database, which is not available to the general public.

- Telephone availability – percentage of calls that are answered
- Appointments with primary care doctors – actual waiting time defined as the amount of time that the patient had to wait after first contacting healthcare until the appointment
- Appointments with specialists – number of patients waiting* (presented in cross-sections or time intervals), actual waiting time* (completed waits) in time intervals
- Examination by specialists – number of patients waiting, actual waiting time
- Surgery/intervention by specialists (a selection of different procedures) – number of patients waiting, actual waiting time in time intervals
- Status report for child and adolescent psychiatry
- Fulfilment of the national care guarantee and Kömiljarden (waiting list billion)

*The waiting period for specialists begins with the decision to refer and ends with the appointment. New measurements begin with the specialist's decision to examine, treat or operate.

In order to provide an instructive forecast, the current status of waiting times is also estimated for specialist care.
Frequency of monitoring
Telephone availability: The measurements have been performed for an entire month each spring and autumn since autumn 2006. Appointments with primary care doctors: ten consecutive weekdays each spring and autumn. Data are available as of autumn 2006. Specialist care: Optional monthly or quarterly reporting. The forecast is updated whenever a change occurs.

Data collection/database
Telephone availability: computerised telephony system. The results of reported data are published approximately one month after measurement has been completed. Primary care appointments: individual health centres enter data in Signe, the national database (soon the data will be automatically transferred from their own patient administration systems). Access to Signe requires a password. The National Board of Health and Welfare and Ministry of Health and Social Affairs also have access to it.

Participation rate
Both private and public care providers. Telephone availability: Only health centres with computerised telephony systems participate.

Quality assurance
Active quality assurance effort. The response rate is monitored and presented publicly.

Presentation
External national website for the general public and healthcare system

Additional information:
www.vantetider.se
National Waiting Time Database, SALAR

Norway

Are waiting times monitored?
Yes, at the national level.

By whom?
Directorate of Health, Norwegian Patient Register (NPR), Statistics Norway

What is studied/what is measured?
- Waiting times for treatment: average number of days after the hospital receives the referral. Measured per four-month period. Broken down by priority patients, others and "all patients," with and without the right to "necessary health assistance."
- Assessment and treatment: number of referred patients who are still waiting at the end of each four-month period.
- Estimated waiting times are reported by hospitals (primarily for the sake of patients).

Follow-up appointments are not included in waiting time statistics, nor are emergency care or delays for medical reasons or due to the patient's choice.

*the first hospital if the patient is subsequently referred to a second one

Waiting times for five main specialties (such as neurology and gastroenterological surgery) are presented. Other figures broken down according to the type of provider (such as medical and psychiatric care). Waiting time statistics are not reported for individual procedures.
**Frequency of monitoring**
New nationwide waiting list statistics are published every four months.

**Data collection/database**
Waiting time data are based on two different reporting formats: “VENTSYS extracts” and “NPR message”. NPR receives and publishes data from “medical hospitals,” as well as institutions that provide psychiatric and interdisciplinary substance abuse treatment. Data are reported to the Norwegian Patient Register either online or by registered letter (CD/DVD).

**Quality assurance**
Waiting time statistics still vary in quality. The rules for reporting data are less ambiguous now, but the system has a ways to go before all institutions apply them uniformly.

**Presentation**
The Directorate of Health website presents statistics from NPR both interactively and in PDF reports. The Norwegian Patient Register reports waiting time figures for five main specialties (such as neurology and gastroenterological surgery). A website (free hospital choice) displays estimated waiting times. The Statistics Norway website shows waiting times for the initial consultation, as well as average waiting time by type of care provider (such as medical or psychiatric care). Waiting time statistics are not reported for individual procedures.

**Additional information:**

**Denmark**

**Are waiting times monitored?**
Yes, at the national level.

**By whom?**
National Board of Health

**What is studied/what is measured?**
- Actual waiting time (Retrospective): all operations (50) and 17 selected operations (median)
- Estimated waiting time (Projected): selected (approximately 200) procedures and operations in 22 areas
- Internal waiting time
- (Not for primary care)

Actual waiting times are based retrospectively on the median number of days from receipt of the first referral by the hospital until final treatment begins. The figure is the sum of all the periods during which the patient has been listed as waiting but not undergoing assessment. It is also referred to as "queue time."

Internal waiting time is the based on the total number of days after the initial referral that are associated with hospital treatment. It consists of two separate periods: until assessment and until treatment. Internal waiting time includes "queue time" (when the patient is registered as waiting) and periods, such as assessment, when the hospital is
involved (processing time). It may also include delays for medical reasons or due to the patient's choice.

**Frequency of monitoring**
Monthly

**Data collection/database**
Based on hospital reporting to the National Patient Register of the Board of Health. Each care event is reported.

**Participation rate**
Includes elective treatment at public hospitals, as well as elective treatment at private hospitals and clinics paid for by the patient's region of domicile as covered by the expanded free choice programme. Reporting of estimated waiting times is not mandatory.

**Quality assurance**
The patient register is conducting an active quality assurance effort.

**Presentation**
External websites, including spreadsheets: Retroactive waiting time: all operations (50) and 17 selected operations, also broken down by hospital and region. Estimated waiting times, mostly for the sake of patients.

**Additional information**
http://www.sst.dk/Behandlingsforloeb%20og%20rettigheder/Ventetider/Ventetider_statistik.aspx,
http://www.sst.dk/~media/408E3BDA78414B1DAFAE7191AA6118B9.ashx

**Finland**

**Are waiting times monitored?**
Yes, at the national level.

**By whom?**
National Institute for Health and Welfare (THL)
THL began operating on 1 January 2009 after the National Public Health Institute and STAKES (Knowledge for Welfare and Health) had merged.

**What is studied/what is measured?**
- Fulfilment of the national care guarantee for primary and specialised care, from assessment of the referral to the outpatient clinic (maximum of 6 months) and from decision to treat until treatment (maximum of 6 months)
- Actual waiting time for surgery, median
- Number of patients waiting in time intervals

**Frequency of monitoring**
The national care guarantee is monitored semi-annually by means of questionnaires that are sent to health centres. Hospitals and other units report to THL every four months according to a report by SINTEF in Norway.

**Data collection/database**
Primary care: questionnaires to health centres. Also for specialist care: "special inquiry" according to THL. AvoHILMO, a nationwide register of primary care, is to contain waiting times but is not ready yet.

**Participation rate**
A total of 156 health centres respond to the questionnaires, the data cover 91 per cent of the population.

**Presentation**
PDF reports. The STAKES and THL website contains some tables in Finnish. The website also contains two different data cubes: one General and one for Psychiatry (Peruskuutio ja Psykiatrion kuutio). Power Play Studio permits extraction of figures by specialty. Number of patients waiting in time intervals. Median waiting times or figures for specific interventions are not available yet.

Statistical Yearbook Finland 2009 contains national average and median figures for certain health specialties, such as the musculoskeletal system and eye region.

**Additional information**
[www.thl.fi](http://www.thl.fi/sampo_prod/cgi-bin/cognos.cgi?b_action=powerPlayService&m_encoding=UTF-8&BZ=IAAAABcHeY4wB42nVO0U7DMAz8GbsDCU1ORiX20ieuLSs0bEDzA2bLIO ulpz9f9JtaA5EEyu_852dpFlNmyp%7ELern3NQZ6uu1_GB9iNVW9hvbYbrAW%7El 8aXFWTkz9OMG0%7EKdbNIVoJwVB163%7EG5%7ESTrXiu7dh2z%7ExC3EY aRItwe%7Ebe3kR4sn3Qq8MQnER0FQYJ7INej5OTsimxWq5rArzEJ%7E8qrcO17 _dPzzJ4ixBoEiQcI1AAilsAk0wHgAThYF3jDQ3zbvtHH3EBGvkm9f9RW0X5DPT 8R6kAn1DHQxnlce8xBIMLGWA](http://www.thl.fi/sampo_prod/cgi-bin/cognos.cgi?b_action=powerPlayService&m_encoding=UTF-8&BZ=IAAAABcHeY4wB42nVO0U7DMAz8GbsDCU1ORiX20ieuLSs0bEDzA2bLIO ulpz9f9JtaA5EEyu_852dpFlNmyp%7ELern3NQZ6uu1_GB9iNVW9hvbYbrAW%7El 8aXFWTkz9OMG0%7EKdbNIVoJwVB163%7EG5%7ESTrXiu7dh2z%7ExC3EY aRItwe%7Ebe3kR4sn3Qq8MQnER0FQYJ7INej5OTsimxWq5rArzEJ%7E8qrcO17 _dPzzJ4ixBoEiQcI1AAilsAk0wHgAThYF3jDQ3zbvtHH3EBGvkm9f9RW0X5DPT 8R6kAn1DHQxnlce8xBIMLGWA)

**England**

Are waiting times monitored?
Yes, at the national level.

By whom?
Department of Health (DH) (UK Gov)
and:
Hospital Episode Statistics (HES), NHS Information Centre for Health and Social Care.

What is studied/what is measured?
DH*:
Waiting times for:
- Audiology
- Cancer waiting times
- Diagnostics
- Inpatient and outpatient hospital
- Sexual Health
- Referral to treatment (RTT)

*From March 2010, Referral to Treatment figures will be the only waiting times figures published by the Department of Health.*
RTT data measure the number of weeks that the patient has to wait from referral to the starting date of the first definitive treatment (18 different specialities, including general surgery and gynaecology). The length of the RTT period is measured for patients whose 'RTT clock' stopped during the month. Data are presented concerning the care provider and principal. The following is required to calculate a patient's RTT period:
• the date of the original referral from primary care or another 'clock starting event'
• the ability to link the original referral to each step on the patient journey
• when the 'RTT clock stopped

HES*:
HES waiting times are worked out as the maximum waiting time at a given provider, such as a hospital. This time is from the date at which the decision is taken to put the patient on a waiting list for admission, until the point at which they are admitted and the treatment takes place. The HES waiting times include days when the patient isn't available for treatment, due to illness or holidays, for example. Such days are called suspensions or deferrals from the waiting list. The mean (average) and median (middle in ranking) waiting time in days for admissions from the waiting list. Time waited in HES is the period between the date of the decision to admit and the date of actual admission. Days of deferment and suspension are not included. Data on number of patients on the list is available. Information is available concerning waiting times for individual interventions, such as cataract surgery.

*There have always been differences between the official, admitted patient waiting times figures collected and published by the Department of Health and the waiting times taken from HES. These differences are due to the different ways in which waiting times are calculated and how suspensions and deferrals are dealt with.

**Frequency of monitoring**
Monthly

**Data collection/database**
Waiting times for referral to treatment (RTT) are collected from NHS care providers (NHS Trusts and other care providers) and removed from the register by principals (commissioners, primary care trusts). NHS reports RTT data to the Department of Health through Unify, the department's digital data collection system.

Hospital Episode Statistics (HES) is a data warehouse containing details of all admissions to NHS hospitals in England. HES is a records based system that covers all NHS trusts in England, including acute hospitals, primary care trusts and mental health trusts. HES records also include care provided to NHS patients by the independent sector, including that taking place in treatment centres, and care given to private patients in NHS hospitals.

The HES database is assembled from records originally generated by the patient administration systems within over five hundred separate English NHS trusts and independent sector organisations. The data in HES comes from the Secondary Uses Service (SUS), which collects data that is passed between healthcare providers and commissioners. At regular intervals during the year providers, such as NHS trusts, submit their data to SUS. Then the data is collected and added to the HES data warehouse. HES collects and holds data based on financial years. At the end of each year an Annual Refresh is processed (giving providers the opportunity to revise and update their submissions), and at this point we close the database and publish the final data.

**Participation rate**
DH: Data completeness indicators are published alongside the RTT data.
HES: over five hundred separate English NHS trusts and independent sector organizations are included.

Quality assurance
DH: Department of Health works closely with organisations to identify problems with data completeness and to ensure that data are as robust and accurate as possible.

HES: While the HES team liaise closely with the NHS and the independent sector in order to maintain data quality and consistency, it is inevitable in such a complex undertaking that a few errors will occur. Users of the data who discover apparent anomalies are encouraged to contact the HES team, so that they may investigate.

Presentation
Spreadsheets on external websites

Additional information
http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=11

Scotland
Are waiting times monitored?
Yes, at the national level.

By whom?
Information Services Division (ISD), Scotland's national organisation for health information, statistics and IT services. (NHS Scotland)

What is studied/what is measured?
Waiting times to accidents and emergency care, audiology, cancer, diagnostics as well as something called “New ways” (new outpatients, inpatients and day cases, whole journey (for cardiac, cataract patients))
  ● Waiting times of patients who are still waiting for health care at a point in time (waiting list census)
  ● Waiting times actually experienced by patients who have been treated (adjusted) http://www.isdscotland.org/isd/5643.html
  ● whole journey cataract: assessment & treatment*
  ● whole journey cardiac: assessment, investigation, intervention* (adjusted) (ongoing waits)

“New Ways” include number of patients seen, number of patients waiting and percentage distribution of wait; by NHS Board and nationally and by patient type (i.e. inpatients/day cases, new outpatients and return outpatients).

*At present, NHS Scotland lacks systems on a national basis to capture total patient journey information. A pragmatic interim solution has been to measure progress towards these targets by measuring and reporting the component parts of the journey:

Frequency of monitoring
Published quarterly. (For additional information, see below)
Data collection/database
Since the introduction of New Ways of Defining and Measuring Waiting Times, the management of waiting times nationally and locally has been achieved through local waiting times information stored in a national data warehouse. Locally, information is updated daily and is then extracted on a fortnightly basis into the Waiting Times Data Warehouse developed by ISD.

Participation rate
A number of NHS Boards report that, due to issues with local systems, there may be some incompleteness in the records returned to the data warehouse at ISD. This is being addressed by ISD and the NHS Boards. Further work is required to understand and assure these data.

Quality assurance
All data are subject to a range of checks on its validity and accuracy prior to publication on this site. Detailed information on validation is available at: http://www.isdscotland.org/isd/4581.html

Presentation
The waiting times section of the ISD website provides the latest information about NHS waiting times in Scotland based on nationally available information.

Additional information
http://www.isdscotland.org/isd/4657.html

Wales
Are waiting times monitored?
Yes, at the national level.

By whom?
Welsh Assembly Government. Health Solutions Wales (HSW)

What is studied/what is measured?
Since March 2010: The main focus of the NHS in Wales is on Referral to Treatment times. This is the total time waited from referral by a GP or other medical practitioner for hospital treatment in the NHS in Wales and includes time spent waiting for outpatient appointments, diagnostic tests, therapy services and inpatient or day-case admissions. RAT Figures are reported in two ways; those waiting for treatment at the end of the month (sometimes known as open pathways) and those treated during the month (sometimes known as closed pathways). The day of referral is defined as the day that the referral letter is received by the hospital.

Trusts will report two sets of monthly aggregate data;
The first extract will show the number of patients by specialty who have reached stop clock points during the reporting period by length of wait in weeks. This completed clock report will be further split by patients reaching a stop clock point due to admission and those reaching a different stop clock point.
- The second extract, the continuing clock report, will show the number of patients by specialty who, at the end of the reporting period, have not yet reached a stop clock point
- by length of current wait in weeks as at the end of the reporting period.

Frequency of monitoring
Trusts are required to report on a monthly basis, on the 25th day of the following month. Thus the report for the period 1st – 30th April will be due on the 25th May.
Data collection/database
Waiting lists are reported by Local Health Boards in Wales and detail all those people resident in Wales who are waiting for NHS-funded hospital treatment and how long they have been waiting. HSW will receive monthly aggregate reports from the Welsh Trusts.

Participation rate
The scope of the data collection is elective treatments for all Welsh Residents whether treated in Wales or elsewhere.

Quality assurance
HSW will process the data and there will be a joint validation with Health Statistics & Analysis Unit (HSA), of the Welsh Assembly Government. HSA will report and publish the data when the collection is of sufficient quality and robustness.

Presentation
The Welsh Assembly Government website presents PDF reports on RTT, as well as waiting times for diagnostic and therapy services, cancer, accidents and emergency care.

Statwales "datalab": StatsWales is a free-to-use service that allows visitors to view, manipulate, create and download tables from the most detailed official data on Wales.

Additional information
http://wales.gov.uk/topics/statistik/theme/hälsovårds/waiting-times/?lang=en

Northern Ireland
Are waiting times monitored?
Yes, at the national level.

By whom?
Hospital Information Branch (HIB) within the Department of Health, Social Services and Public Safety (DHSSPS) publishes information on hospital waiting lists and waiting times on a quarterly basis within the “Northern Ireland Waiting List Bulletin” and “Northern Ireland Cancer Waiting Times Bulletin.”

What is studied/what is measured?
A point in time measurement of people currently waiting for outpatient /diagnostic /inpatient /cancer and emergency care services analysed by length of time waiting for various specialties. Waiting time for inpatients begins from the date the clinician decided to admit the patient.

Waiting time for a first outpatient appointment begins on the date the Health and Social Care (HSC) Trust receives a referral for a first appointment and ends on the date the patient attends a first outpatient appointment. (The same goes for diagnostic services.)

The number of patients attending a first outpatient appointment and the number admitted for inpatient surgery are also presented for each quarter.

Frequency of monitoring
Presented quarterly

Data collection/database
Hospital Information Branch is responsible for the collection, quality assurance, primary analysis and publication of timely and accurate information derived from a wide range of statistical data supplied by the Health and Personal Social Services
(HPSS). Data are provided routinely through various computerised patient information systems or by manual returns.

**Presentation**

Northern Ireland Waiting Times Bulletin (PDF online) contains information relating to the number of people waiting at the end of each quarter for:
- a first outpatient appointment;
- a first appointment at an Integrated Clinical Assessment and Treatment Service (ICATS);
- a diagnostic service;
- admission for inpatient treatment.

Data are presented by HSC Trust and Specialty and are also available in excel format.

**Additional information**

http://www.dhsspsni.gov.uk/index/stats_research/stats-activity_stats-2/waiting_times_main.htm

**Ireland**

Are waiting times monitored?
Yes, at the national level.

By whom?
*Patient Treatment Register (PTR), National Treatment Purchase Fund (NTPF)*

What is studied/what is measured?
Public hospital in-patient, day-case surgical and medical waiting lists.
Waiting volume (number) in intervals per hospital, surgical procedure and medical cases (children and adults). Median waiting time (months) for 20 different surgical procedures per hospital (adult and children). Median wait times are calculated from the date the patient is placed on the in-patient or day-case waiting list by the hospital.

Frequency of monitoring
Monthly

Data collection/database
In 2009 a total of 44 hospitals nationally submitted waiting list data to the PTR.

Participation rate
44 hospitals (2009). Those without waiting lists are not included.

Quality assurance
Hospitals are responsible for the accuracy of data submitted to PTR. To support the hospitals in this regard and to confirm that National Waiting List Data Management Guidelines are in use, the NTPF has established a review and analysis section to ensure accuracy of data in the hospitals through spot check analysis. Disclaimer: Data in the Patient Treatment Register (PTR) is provided directly by participating hospitals. The accuracy and currency of the PTR reports are entirely dependent on the data hospitals submit.

Presentation
NTPF website for physicians and the general public. "Average waiting times" are available online, as well as PDF reports with specific interventions, such as cataract surgery. Each hospital can access the information in respect of their own waiting list.

**Additional information**

Canada

Are waiting times monitored?
Yes, at the national level.

By whom?
Canadian Institute for Health Information (CIHI)

What is studied/what is measured?
The median, 90th percentile and proportion of patients who receive care within pan-Canadian benchmarks for all priority-area procedures. All provinces are now able to report against benchmarks for cancer, joints and cataract procedures, while CIHI provided data on waits for hip fracture surgery.

Cancer – wait times for radiation therapy and chemotherapy.

Joint replacements – wait times for total hip and total knee replacement surgeries.

Vision restoration – wait time for cataract removal from the first eye.

Heart – wait times for cardiac bypass surgery (i.e. coronary artery bypass grafting) and angioplasty.

Diagnostic imaging – wait times for MRI and CT scans, which meet appropriateness guidelines; used for diagnosis.

Emergency Department Wait Times

A wait time is defined as the number of days between a start date (when the patient and physician agree to a service and the patient is ready to receive the service) and a finish date (when the patient receives the service or the initial service in a series). The appropriate physician is one with the authority to determine the needed service.

The time of first inpatient admission with a hip fracture (index admission) to the time when hip surgery was received.

Participation rate
All provinces

Quality assurance
“At CIHI, everything we do is about the quality of our data. Through our comprehensive data quality programs, we work hard to ensure that the quality of the information in our data holdings is suited to its intended uses and that data users are provided with good information about data quality.”

Presentation
External website of CIHI and the provinces, as well as an annual PDF report: Wait Times Tables—A Comparison by Province, 2010, released in March 2010, reports on patient wait times for five priority areas identified by Canada’s first ministers in 2004: cancer treatment, cardiac care, sight restoration, joint replacement and diagnostic imaging.

Additional information
http://www.cihi.ca/CIHI-ext-portal/internet/EN/SubTheme/hälsovårds+system+performance/access+and+wait+times/cihito10647
New Zealand

Are waiting times monitored?
Yes, at the national level.

By whom?
National Booking Reporting System (NBRS), Ministry of Health

What is studied/what is measured?
NBRS contains information by health specialty and booking status on how many patients are waiting for elective surgery, and how long they have had to wait before receiving it.

(Fulfilment of guarantees)

Frequency of monitoring
Monthly

Data collection/database
Hospitals have been required to report data since 1 August 2000. Data are provided by public hospitals in New Zealand.

The NBRS contains details of all booking status events involving a healthcare user who:
- receives a priority for an elective medical or surgical service, and
- is likely to receive publicly funded treatment.

Information is collected about the patient’s date of entry into the system, their assessed priority, and their booking status.

Participation rate
Public hospitals are required to provide data.

Presentation
Ministry of Health, external website

Additional information

Austria

Are waiting times monitored?
The lack of transparency regarding waiting times in Austria has been criticized by Austrian researchers. The Austrian Minister of Health recently announced that there will be an Austrian-wide transparent waiting time regime for elective surgeries. Due to this fact, each Austrian province must provide a transparent waiting time/list management. The Viennese waiting time time/list management, which was introduced in 2008, should serve as an example for it.

The responsibility of the provinces to provide transparent waiting times/lists will be regulated by a national law (amendment to the national law: Kranken- und Kuranstaltengesetz (KAKuG)).
The framework/legal obligation for the introduction for the Austrian-wide transparent waiting time regime is done on national level, but the implementation is done on provincial level. [26]

Spain

Are waiting times monitored?
Yes, at the national level

By whom?
Servicio Nacional de Salud (SNS), under the Ministry of Health

What is studied/what is measured?
A selection of surgical specialties (especialidades) and interventions/operations (procesos), as well as appointments with specialists

Variables monitored:
Surgical procedures:
- total number of patients waiting (total pacientes en espera estructural) for surgery
- number of patients waiting per 1 000 inhabitants
- average number of days waiting, ongoing waits
- Percentage of waiting patients who have been waiting for longer than six months
Appointments:
- total number of patients waiting (total pacientes en espera estructural)
- number of patients waiting per 1 000 inhabitants
- average number of days waiting, ongoing waits
- percentage who have been waiting for longer than 60 days

Frequency of monitoring
National annual monitoring

Presentation
PDF documents on the Ministry of Health website

Additional information
http://www.msc.es/estadEstudios/estadisticas/inforRecopilaciones/listaEspera.htm
http://webcache.googleusercontent.com/search?q=cache:4DfCahNSnDUJ:www.msc.es/gabinetePrensa/notaPrensa/desarrolloNotaPrensa.jsp?id=1909+garant%C3%ADa+de+tiempos+m%C3%A1ximos+de+espera+en+la+atenci%C3%B3n+sanitaria&cd=2&hl=sv&ct=clnk&gl=se

Australia

Are waiting times monitored?
Yes, at the national level.

By whom?
National elective surgery waiting times data collection (NESWTDC), Australian Institute of Health and Welfare (AIHW). Other data on elective surgery waiting times are available in Australian Hospital Statistics.

What is studied/what is measured?
Three data cubes are available on elective surgery waiting times. They contain information for:
• Reason for removal, 2002-03 to 2007-08
• Surgical specialty, 2001-02 to 2007-08
• Indicator procedure, 2001-02 to 2007-08 (such as hip replacement, cataract)

The variables in the data cubes are:
• Year
• State/territory

The measures (values) in the data cubes are:
• Number of records
• Waiting time at the 50th percentile (days)
• Waiting time at the 90th percentile (days)
• Proportion of patients waiting more than 365 days

The data elements listed below form part of the National Minimum Data Set for Elective Surgery Waiting Times:
• Extended wait patient
• Indicator procedure
• Overdue patient
• Reason for removal from elective surgery waiting list
• Specialty of surgeon
• Clinical urgency
• Waiting time at removal from elective surgery waiting list

Waiting time: The time elapsed between a service request and a subsequent administrative or service event. For elective surgery, the listing date is the date on which the patient is added to an elective surgery waiting list defined as the date on which a hospital or a community health service accepts notification that a patient/client requires care/treatment. (The acceptance of the notification by the hospital or community health service is conditional upon the provision of adequate information about the patient and the appropriateness of the patient referral.)

Data collection/database
Data are supplied by the state and territory health authorities. It is a collection of electronic confidentialised summary records for patients on elective surgery waiting lists and patients removed from waiting lists (for admission or another reason). National elective surgery waiting times data collection (NESWTDC).

Participation rate
The collection is based on public acute care hospitals only. However data for some smaller public hospitals are not collected. Private hospitals are generally not included.

Quality assurance
The National health data dictionary definitions form the basis of the data collection, ensuring a high standard of data comparability.

Presentation
External website with interactive spreadsheets. PDF report of Australian Hospital Statistics 2008-09. The AIHW provides extracts from the National elective surgery waiting times data collection (NESWTDC) on request. A charge may apply. The amount charged will depend on the extract requirements and the complexity of the analysis undertaken.

Additional information
Portugal

Are waiting times monitored?
Yes, at the national level.

By whom?
SIGIC (“Sistema Integrado de Gestão de Inscritos para Cirurgia”), which is the Ministry of Health's executive unit, responsible for improving access to surgery in Portugal. SIGIC reports to the board of ACSS (“Administracão Central do Sistema de Saúde,” the Health System's Central Administration). [50]

What is studied/what is measured?
- Number of people on the surgery waiting list
- Median waiting time for people on the surgery waiting list
- Percentage of those on the list who have been waiting longer than the upper limits of the waiting time guarantee
- Number and percentage of those on the waiting list who have been waiting for more than one year
- Average waiting time for patients who have undergone surgery (completed waits)

Waiting times are also reported at the regional level and for various specialties.

Measurement of waiting time begins when the primary care doctor enters the referral in the CTH system.

Data collection/database
SIGLIC (“Sistema Integrado de Gestão da Lista de Inscritos para Cirurgia”) is the IT software installed at hospitals through which the SIGIC unit keeps track of their performance with respect to surgery. The information is entered and integrated on a daily basis with the central SIGIC database. [21]

Participation rate
In 2009, a total of 66 public and 54 private hospitals belonged to the SIGIC network.

Quality assurance
Standardised rules determine how information is to be entered. SIGIC conducts informational campaigns and trainings to ensure quality. A reporting system identifies transaction errors and a tool is available to reject “non-compliant data.”

Presentation
Some statistics are available online as PowerPoint presentations.

People can see online where they are on the waiting list and how long they will have to wait for surgery.

Additional information
(in Portuguese)
http://www.portaldasaude.pt/portal
http://www.portaldasaude.pt/portal/conteudos/informacoes+uteis/lista+de+inscritos+par+a+cirurgia/RelatorioIndicadores1Semestre2010.htm
http://www.dre.pt/pdf1sdip/2008/07/13300/0440804414.PDF
Italy

Are waiting times monitored?
Funds have been earmarked for a national campaign to provide citizens of all regions with online information. Thirty-three percent of the regions currently report aggregate data online, but not all health centres within these regions report. Individual health centres can report online even if no aggregate data are available for that region.

What is studied/what is measured?
Completed and expected waits

Presentation
Some information is available online.

Current status of waiting times
There is anecdotal evidence of long waiting times and differences between the northern and southern regions. [51] Even EC Country Fiches mentions that the population perceives that waiting times for surgery and specialist appointments are long and that there are substantial regional variations. [52]

Additional information
http://www.salute.gov.it/qualita/paginaMenuQualita.jsp?menu=liste&lingua=italiano

Netherlands

Are waiting times monitored?
Yes, since 2008 hospitals are required to update waiting times on a monthly basis in accordance with the definition of the supervisory authority. These data are occasionally compiled at the national level.

By whom?
The Dutch Ministry of Health (VWS) commissioned the National Atlas of Public Health, developed and coordinated at the “Department of Public Health Status and Forecasting” which is part of the National Institute of Public Health and the Environment (RIVM). Nationwide, experts, research institutes and universities have contributed to the Atlas in their area of expertise. Mediquest collects the data from the hospitals’ webpages.

What is studied/what is measured?
Waiting lists – hospitals:
Waiting time for outpatient care, for specific procedures and for diagnosis

Average effective time for the past three months, rounded to whole weeks. Waiting time in outpatient care is the number of days from the date that the patient makes an inquiry until the first appointment. Waiting time for treatment is the number of days from the date that the attending physician informs the patient that surgery is indicated until the operation is performed.

Waiting lists, care and treatment (number of patients waiting per 1 000 inhabitants, 2005)
Waiting lists, disability care (number of patients waiting per 100 000 inhabitants, 2005)
Waiting lists, adolescent care (number of patients waiting per 100 000 inhabitants, 2009)

Frequency of monitoring
Since 2008, hospitals are required to update waiting times on their websites once a month. The overview is updated four times a year.

**Participation rate**
Public and university hospitals

**Quality assurance**
Both waiting lists and waiting time data suffer from flaws, but improvements have been made.

**Presentation**
The Dutch National Atlas of Public Health is a web-based Atlas that maps the regional distribution of health related matters. It includes information not only on the occurrence of certain health issues – such as epidemics, vaccinations or obesity – but also on the geographic spread of related variables. “Click maps” with bubbles of different sizes.

**Current status of waiting times**
In the Dutch Health Care Performance Report (DHCPR) 2010, the timeliness of regular care is determined first on the basis of data from surveys conducted among citizens. The data tells us something about how people experience waiting for care. In addition, registration data is presented for waiting lists and waiting times for mental health care, hospital care and long-term care. Still, it is known that in 2009 the waiting times for common procedures for varicose veins, inguinal hernia, slipped disk and cataract were below the Treek norm, and that waiting times for breast reconstruction, knee replacement and hip replacement exceeded the norm by far.

Waiting for regular care has shown little change in recent years. Some sectors improved slightly, while others took a slight turn for the worse. Over 22% of patients experienced waiting for care as a problem. The indicators used do not give an exhaustive overview of the bottlenecks, but they do give some signals. The number of people waiting for mental health care has increased significantly. The main groups of problematic patients on the waiting list are people with dementia waiting for a place in a nursing home and young people with a slight mental disability.

The Healthcare Authority’s monitor revealed that most specialties showed a reduction in waiting times and that the waiting times for almost all common treatments declined in the year 2009. (Source: DHCPR 2010). [53]

**Additional information**
http://www.zorgoversikt.nl/
http://www.treeknorm.nl/
http://www.nationaalkompas.nl/zorg/sectoroverstijgend/welke-normen-zijn-er-voor-aanvaardbare-wachtperioden-in-de-zorg/
http://www.gezondheidszorgbalans.nl/onderwerpen/toegankelijkheid/tijdigheid-reguliere-zorg/wachtperioden-ziekenhuizen/

**Germany**

**Are waiting times monitored?**
No national monitoring [54]

**Current status of waiting times**
Germany says that it has no problems with long waiting times. [23] However, a discussion is under way concerning waiting time inequities linked to different types of health insurance, i.e., the 10 per cent of the population that has private insurance obtains
faster care than the 90 per cent with statutory insurance. Some experts argue that the situation applies only to outpatient care [55, 56], whereas other studies have found a similar problem for inpatient care. [22]

Additional information
http://www.bundesgesundheitsministerium.de/glossarbegriffe/gesundheitssystem.html

Greece

Are waiting times monitored?
No national monitoring

Current status of waiting times
The Health System in Transition Review on Greece from the European Observatory on Health Systems and Policies state that a major quality problem of Greece health care is waiting lists. It is stated that anecdotal evidence shows that in some hospitals patients may need to wait for three or even six months before having elective surgery. The waiting time for radiation therapy for patients suffering from cancer is approximately three months. In many cases, the same waiting time is required for an operation to remove a tumour. There are some hospital outpatient departments that take at least 5–6 months to arrange an appointment. The waiting time for a mammography is approximately 3–6 months and for a pap test 2–3 months. However, it must be kept in mind that this information is merely indicative. The underdevelopment of hospital information systems, the absence of an organised central or regional department to collect and process data and, more importantly, the non-existence of a national policy on waiting lists make data recording incomplete.

Further it is stated that an extensive black economy and informal payments are common features of the Greek health sector. The transactions mainly concern the provision of hospital services and payments to physicians, primarily surgeons, so that patients can bypass waiting lists or ensure better quality of service and more attention from doctors. [28]

A survey, using a sample of 4,738 individuals, concluded that 36% of those treated in a hospital reported at least one informal payment to a doctor. Of these, 42% reported that the payment was given because of the fear of receiving substandard care and another 20% claimed that the doctor demanded such a payment. The probability of making extra payments is 72% higher for patients aiming to “jump the queue”, compared to those admitted through normal procedures. [57]

Additional information
http://www.euro.who.int/__data/assets/pdf_file/0004/130729/e94660.pdf

France

Are waiting times monitored?
No national monitoring [27]

Current status of waiting times
The French health care system was ranked as number one in the world by the World Health Organization in 2000. This was largely due to the availability of a plentiful supply of providers, a high degree of freedom for physicians and patients, few restrictions on the range of services covered by statutory health insurance, easy access to health care and the absence of waiting lists for treatment, all of which resulted in substantial levels of patient and public satisfaction with the health care system. [58, 59]
However, very few data are actually available on timelines for various types of care, such as emergency care and planned surgery, as well as time spent in waiting rooms of doctors’ practices. [27]

To justify this lack of information, it is often considered that waiting times are not a problem in France. Yet there are wide variations between regions in the provision of specialist care not only in the hospital but also in town. One of the few investigations available, made in 2004, found that the median waiting time for an appointment is about 25 days, that this period can be more than two months for an ophthalmologist and an endocrinologist 50 days. Access to general practitioners however, seems to be quite satisfactory with over 80% of patients reporting getting an appointment within 48 hours. [27]

Belgium

Are waiting times monitored?
No national monitoring [60]

Current status of waiting times
High capacity in the Belgian healthcare system results in very rare waiting lists and very short waits. [52] Patients do not usually have to wait long for access to either general practitioners (GPs) or specialists and waiting lists for e.g. hip replacements are limited. People are free to choose which hospital they visit and public hospitals have to accept all patients. There is no formal referral system between primary and secondary/tertiary care, but, in practice, it is usually the GP or the private specialist who decides to send the patient to a hospital. Waiting lists are quite rare in Belgian hospitals and not considered to be a problem. For specific interventions, waiting lists may occur due to external reasons, such as the shortage of donors in the case of organ transplantation. [61]

Luxembourg

Are waiting times monitored?
Could not be confirmed

Current status of waiting times
Luxembourg health care is based on a very comprehensive compulsory health insurance system and 96.8% of all citizens and registered residents are covered by a statutory health insurance system. There are indications that long waiting lists for surgery exist. [52]

United States

Are waiting times monitored?
Some monitoring is conducted. [29]

Current status of waiting times:
Access to care varies according to socioeconomic status and geographic area. In 2009, 15.4 per cent of the U.S. population (46.3 million people) were uninsured and had limited access to health care. [16, 17, 29] The fact that they are not included in waiting time statistics may be one reason that the United States is often reported to have short queues for elective care. [16] The objective of President Obama’s Patient Protection and Affordable Care Act is to broaden coverage such that all citizens have access to the healthcare system. [62]
Appendix 2. National Care Guarantees

Identifying the countries that have some type of national care guarantee, how it is designed and how well it is fulfilled adds an extra dimension to waiting time comparisons. Below is a presentation of the 15 countries that have some kind of national guarantee.

<table>
<thead>
<tr>
<th>Country</th>
<th>Description of guarantee</th>
<th>Example of fulfilment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden 0-7-90-90 [3]</td>
<td>0 - Contact with primary care the same day 7 - Appointment with primary care doctor within seven days 90 - Appointment with specialist within 90 days of decision to refer 90 - Specialist treatment within 90 days of decision to treat</td>
<td>9 out of 10 patients receive care within the upper limits of the guarantee [3]</td>
</tr>
<tr>
<td>Denmark Utvided frit sygehusvalg [63]</td>
<td>Free choice among all public hospitals. If a patient has to wait for assessment or treatment for more than one month, the choice is expanded to include private hospitals and hospitals abroad that have signed agreements. (Psychiatric treatment or assessment within two months) Maximum waiting times for patients with life-threatening cancer or heart disease</td>
<td>The National Board of Health does not keep statistics about this. [64] A median waiting time of 38 days for elective surgery should indicate that under half of the patients undergo surgery within the upper limits. (Author's comment)</td>
</tr>
<tr>
<td>Finland</td>
<td>Statutory national care guarantee  Health centres  - Weekdays when the health centre is open: immediate contact by visiting or phoning.  - If the patient requires care, an appointment is to be scheduled within three weekdays of phone contact.  - Non-urgent care is to begin within three months of the date that the need was determined.  Specialised health care  - If the health centre provides specialised care, it is to begin within six months.  Hospitals  - Admission to hospital requires a doctor's referral.  - The hospital is to assess the patient's need for care within three weeks after receiving the referral.  - The assessment can be made on the basis of the referral or an appointment may be scheduled for examinations.  Admission for care  - Hospital care is to begin within six months of the date that the need was determined.</td>
<td>Spring 2010: Approximately one-fourth of the population receives an appointment with a health centre doctor within two weeks. But almost one-fifth of the population must wait for more than four weeks. An appointment with a nurse can still be scheduled within three days for two-thirds of the population and one week for 84 per cent. However, there are large regional differences. Half of the population live in an area where it is difficult at times to make immediate contact with the</td>
</tr>
</tbody>
</table>
- If a patient's health centre or hospital cannot provide care within the specified time, the patient is to be given the opportunity to receive care elsewhere in the public or private sector at no additional cost. The patient is also entitled to refuse any care that is offered. [65]  

| Norway Free choice of hospital | A patient who is referred to hospital is entitled to receive a health assessment within 30 days. Patients younger than 23 with psychological or substance abuse problems have the right to be assessed within 10 days. Certain patients are given priority in order to assure that those with the greatest need are treated first. Among the criteria for selecting priority patients are severity of the condition and the potential for improvement. Those who need specialist care but are not regarded as priority patients must be offered treatment as well, though they will have to wait somewhat longer. Priority patients are entitled to receive an individual treatment deadline from the hospital. In accordance with the free choice of hospital programme, a patient who is referred for specialist assessment, examination or treatment has the right to select a hospital or locality. The right applies to all elective examinations and assessments for medical and psychiatric care, as well as interdisciplinary, specialised substance abuse treatment. | The Norwegian patient register does not have complete national statistics on the number of deadlines passed. [68] |
| England | The previous ‘18-week’ guarantee has been eliminated. | At national level, 93.3% of admitted patients and 98.1% of non-admitted patients completed their RTT pathway within a maximum of 18 weeks. [69] |
| Northern Ireland The 2010/11 Priority for Action Target | - As of March 2011, no patient is to wait longer than 9 weeks for an initial specialist appointment (outpatient consultation)  
- As of 31 March 2011, no patient is to wait longer than 9 weeks for a “first Tier 2 consultation at Integrated Clinical Assessment and Treatment Services (ICATS). | Ongoing waits: At the quarter ending September 2010, 40.6% of patients waited more than nine weeks for a first outpatient appointment (52,326 |
- As of 31 March 2011, no patient is to wait longer than 9 weeks for a diagnostic service. By 31 March 2011, the majority of patients should wait no longer than 13 weeks for inpatient or day case treatment, with no patient waiting longer than 36 weeks.

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
<th>Percentage/Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>The National Treatment Purchase Fund (NTPF) arranges care at a private hospital if the patient has been waiting for more than three months for care at a public hospital. [71]</td>
<td>There are 18,319 patients waiting &gt; 3 months for treatment (April 2010) There are 19,377 patients waiting &gt; 3 months for treatment (Nov 2010) [37, 72]</td>
</tr>
<tr>
<td>Scotland</td>
<td>National maximum waiting times: 12 weeks treatment as inpatient or day case (9 weeks as of March 2011) 12 weeks new out-patient appointment at a consultant led clinic 6 weeks for 8 selected diagnostic tests 18 weeks &quot;Whole journey from general practitioner referral to treatment&quot; (cardiac) 18 weeks Whole journey from referral by a GP or optometrist to cataract surgery 16 weeks Coronary heart disease 62 days from urgent referral with a suspicion of cancer to treatment and from decision to treat to first treatment 31 days (as of Dec 2011) 24 hours hip fracture [73]</td>
<td>For the quarter ending on 30 September 2010: Approximately 98% receive treatment as inpatient or day case within 9 weeks. Approximately 98% of new outpatient appointments occur within 12 weeks. [36]</td>
</tr>
<tr>
<td>Wales</td>
<td>26 weeks from GP referral to treatment (including waiting times for any diagnostic tests and therapies required). 36 weeks apply if the wait is due to medical reasons or the patient's choice. Some specific services are excluded from referral to treatment reporting. These include palliative care, mental health hospital services and inpatient/day-case dentistry. [74]</td>
<td>Of the patients who were treated during December 2010, 90.1% were treated within 26 weeks and 98.5% were treated within 36 weeks of the date the referral letter was received at the hospital. [75]</td>
</tr>
<tr>
<td>Spain</td>
<td>180 days: Heart valve, coronary vessel, cataract, hip replacement, knee replacement surgery [76]</td>
<td>Number of patients on the waiting list on 31 June 2010 who had waited</td>
</tr>
<tr>
<td>Country</td>
<td>Access Time</td>
<td>Waiting Time</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Netherlands</td>
<td><strong>Treek norm</strong></td>
<td>On 1 December 2009, waiting times for diagnosis and treatment exceeded the Treek norm in 18.7% and 14.8% of hospital departments respectively. Still, it is known that in 2009 the waiting times for common procedures for varicose veins, inguinal hernia, slipped disk and cataract were below the Treek norm, and that waiting times for breast reconstruction, knee replacement and hip replacement exceeded the norm by far (NZa, 2010a). In 2009, waiting times for outpatient clinics increased (see Table 3.5.3). On 1 January 2009, 24.1% of outpatient clinics exceeded the Treek norm, to have increased to 27.5% on 1 December 2009. In contrast, the percentage of hospital departments exceeding the Treek norm for treatment and diagnostics decreased (NZa, 2010a).</td>
</tr>
<tr>
<td>Italy</td>
<td><strong>Piano nazionale di governo delle liste di attesa (PNGLA) 2010-2012.</strong></td>
<td>No national summary found</td>
</tr>
<tr>
<td>Canada</td>
<td><strong>Health care wait guarantees</strong></td>
<td>At least 8 out of 10 Canadian patients are receiving priority area procedures, such as hip replacements, cataract</td>
</tr>
<tr>
<td>Country</td>
<td>Clarity – right to information concerning availability of examinations and treatment.</td>
<td>Timeliness – Notification within 10 days concerning access to assessment or treatment. Any treatment is to be provided within 6 weeks.</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| New Zealand| As of December 2010, radiotherapy is to be provided within 4 weeks.  
|            | all patients referred to hospital by their GP who can be seen within the available resources, are seen for a first specialist assessment within six months       | all patients assigned a priority by a specialist are managed in accordance with that priority (relative to the priorities assigned to other patients managed by that service) | all patients given a commitment to getting treatment receive that treatment within six months   | all patients have a plan of care [78] |  
|            | Dec 2010: 100% appropriately acknowledge and process all patient referrals within ten working days. Patients waiting longer than six months for their first specialist assessment range from 0 to 2.5% for various specialties (elective surgery). Patients given a commitment to treatment but not treated within six months range from 0 to 4.6% for various specialties (elective surgery). Patients who have not been managed according to their assigned status and who should have received treatment range from 0 to 2.8% for various specialties (elective surgery) [79] |  
| Portugal   | Each healthcare institution is to base its guaranteed response time on the type of service involved, within the limits of the national guarantee. All institutions that belong to the SNS (Serviço Nacional de Saúde) and the "contractual sector," including the private and public sector, are required to provide patients with up-to-date information about guaranteed response times at the national level and their own institution. | Care at health centres at the patient's request:  
|            | Acute conditions – appointments/consultations ("atendimento") on the day of the request  
|            | Non-acute conditions – within 15 business days of the date of the request  
|            | Renewal of prescriptions for chronic conditions, reports, referrals, advice and other written documents – 72 hours after submission of the request. Consultation at home at the patient's request – 24 hours if the caregiver accepts the request. |  
|            | One 31 Dec 2009, 19.4% of patients on the waiting list for elective surgery had waited longer than the maximum. 10.4% (n=17 082) had waited longer than one year, a decrease of 81% since 2005 (n=89 930), [32] |  
|            | surgery and cancer radiation treatment, within medically recommended wait times, however, there is wide variation in wait times across Canada. [77] |
SNS hospitals:
Initial consultation with a hospital specialist after referral from a health centre:
as of the date that the referral from the primary care unit is entered, taking clinical priority into
consideration:
30 days if the consultation is assigned top priority
60 days if the consultation is assigned high priority
150 days if the consultation is assigned normal priority
If response times exceed the above, the attending physician is authorised to refer the case to another SNS
hospital, assuming that the patient agrees
Elective surgery:
Priority level 4 – 72 hours after indication of surgery
Priority level 3 – 15 days
Priority level 2 – 60 days
Priority level 1 – 270 days
Elective cancer surgery – from 72 hours for priority level 4 to 60 days for priority level 1

Institutions that have signed agreements [80, 81]
Appendix 3. Other International Comparisons

Below is an overview of studies that have compared waiting times and related topics among different countries. The focus is on the parts of the studies that specifically concern the quantification of waiting times.

**Hurst and Siciliani:** *Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries.* 2003
The report discusses waiting times as a phenomenon and compares “policies to tackle excessive waiting times” in 12 OECD countries. The comparison is based on a questionnaire that was sent to the countries that participated in the OECD Waiting List Project in April 2002: Australia, Canada, Denmark, Finland, Ireland, Italy, the Netherlands, New Zealand, Norway, Spain, Sweden and the UK. The report advances the theory that there is an optimum operation frequency and waiting time (greater than zero), given that a queue of a certain length can provide major savings in terms of surgical capacity without imperilling the health of patients. Various demand-side and supply-side policies are discussed, along with examples from the various countries. Considering that the policies are rarely evaluated, however, the report argues that it is difficult to draw any conclusions as to which ones have proven successful. A key finding is that waiting times are quantified differently from country to country, the biggest distinction being between those that measure “waiting times for patients admitted” and those that measure “waiting times of the patients on the list at a census date.” According to the report, both parameters should be measured. [82]

**Siciliani and Hurst:** *Explaining waiting-time variations for elective surgery across OECD countries.* 2003
The next report of the OECD Waiting List Project explores whether a number of variables can explain waiting time differences among the countries that say that they experience problems, as well as between these countries and those that say that they do not experience problems. The first group of countries consists of the 12 participants in the project (see above). The second group consists of Austria, Belgium, France, Germany, Japan, Luxembourg, Switzerland and the United States. Data were collected by means of a questionnaire concerning ten different elective procedures that was sent to administrative sources in the 12 countries. The most common definition of waiting time was: “The time elapsed for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure, after specialist assessment, to the date they were admitted to an inpatient or day-case surgical unit for the procedure.” The report does not indicate which countries use the definition. Nor does it mention the other definitions that are used or the implications they might have for the waiting time figures presented. The countries with the longest reporting waiting times are England and Finland, followed by Denmark, Norway, Australia and Spain. The Netherlands has the shortest waiting times among the countries that report that they experience problems. The Swedish statistics concern cataract surgery only (average = 199 days – the third worst, ahead of England and Finland). The countries without waiting time problems average more money spent on health care, have higher capacity (measured as the number of doctors and emergency beds), and are more likely to have activity-based hospital financing and fee-for-service arrangements (instead of salaries) for doctors. The two groups of countries do not differ significantly in terms of healthcare needs, measured as mortality and the percentage of elderly in the population, or in the degree of cost-sharing. The report concludes that the issue has been inadequately studied and urges further research. [6]

**Standing Committee of the Hospitals of the EU (HOPE):** *Waiting Lists and Waiting Times in Health Care, Managing Demand and Supply.* 2001
The report was published by a HOPE task force with participants from Sweden, Spain, Finland, Ireland and the Netherlands. The minimum data requirements for effective management and monitoring of waiting lists and waiting times are described, as well as the experience of the various countries with respect to waiting list policies, prioritisation systems and online patient information systems. Also discussed are the financing systems that work best in relation to waiting times, as well as who determines what waiting times are appropriate. One conclusion is that discrepancies in the way countries report waiting times may contribute to the variation in results. [10]

**Standing Committee of the Hospitals of the EU (HOPE): Measuring and Comparing Waiting Lists: A study in four European countries. 2004**

This questionnaire study covers: 1. Processes and waiting times for three interventions: bypass (CABG), cataract and hip replacement surgery. 2. Referral and treatment processes, as well as reporting and monitoring of waiting times for elective surgery. The questionnaire was sent to three hospitals each in Sweden, Ireland, Spain and Finland, but the response rate varied. Data for bypass surgery are presented for only one (Irish) hospital. The authors conclude that the other two procedures show large variations both within and between countries, but that the waiting times presented in the study are shortest for Spain. The study finds that reporting and monitoring differences make it hard to compare waiting times among various countries. Another difficulty is that the definition of waiting time varies from one country to the next. [48]


The HealthACCESS project explores issues that affect cross-border access in 10 countries: Austria, Belgium, England, France, Germany, Ireland, Italy, Poland, Hungary and the Netherlands. The basic parameters are six access hurdles, one of which is organisational (including waiting times). Studies of relevant literature sources and websites are supplemented by a questionnaire sent to ten researcher in each of the ten countries. England, Ireland, Italy, Poland and the Netherlands report that they have formal waiting lists. Inequities in healthcare access have been noted in France, Germany and Ireland, while information payments are mentioned in Hungary. [19]


The report ranks European healthcare systems from the viewpoint of consumers. The ranking is based on an index of six subdisciplines consisting of 38 indicators. A country can score up to 1000 on the index. Waiting times, which represent one of the subdisciplines, consist of the following indicators. 1. Family doctor same day access, 2. Direct access to specialist, 3. Major non-acute operations < 90 days, 4. Cancer therapies < 21 days, 5. CT scan < 7 days. The contributions of the subdisciplines to the total score are weighted by degree of urgency. Following discussions with a panel of experts, the weights of the subdisciplines of waiting times and medical outcomes were increased the most. The report does not claim to have been conducted in a scientific manner and admits that the results suffer from data quality problems. Nevertheless, the authors hope that the report will be a source of inspiration for improving health care. Data for the subdiscipline of waiting times were collected by means of a questionnaire that was sent to patient organisations, 602 of which responded – at least one in each country. Feedback was also obtained from “National ministries/agencies” concerning the preliminary scores. Proposed changes supported by concrete data were accepted. The results for countries that obtained reliable information from ministries and agencies were based solely on such information and responses to questionnaires were used only when they differed radically. No sources are given for the data provided by the ministries and agencies. Nor are there any clues as to what the patient organisations based their responses on.

The Netherlands scores the highest, followed by Denmark, Iceland and Austria. Sweden has the highest score on medical outcomes and “range and reach of services provided”
but is in ninth place overall due to a low score on the subdiscipline of waiting times. Portugal and Great Britain have the lowest waiting time scores (80) followed by Spain, Sweden and Finland (93). At 187, Albania, Belgium, Germany and Switzerland score the highest.

[7]

Survey of Health, ageing, and retirement in Europe (SHARE): is an interview study based on a sampling of the European population age 50 or older. Spouses were also interviewed regardless of age. The study was conducted among 1 000 – 3 000 people in each of ten countries in 2004, 2006/07 and 2008. [83] Of the various publications to which the study has given rise, we found two that deal with waiting times in one way or another:

Mojon-Azzi and Mojon: Waiting times for cataract surgery in ten European countries: An analysis using data from the SHARE survey. 2006
The analysis covered Austria, Germany, Sweden, the Netherlands, Spain, Italy, France, Denmark, Greece and Switzerland. Those in the 22 777-member SHARE 2004 study population who stated that their most recent surgery was for cataracts were asked how long they had to wait. There is no indication as to the point in the patient journey at which they started to wait. A total of 245 of 251 possible responses were obtained. Swiss patients reported the shortest waiting times (average of 1.3 months). Spanish (6.2 months) and Swedish (5.8 months) patients were the only ones who reported significantly longer waiting times than Swiss patients. [21]

Siciliani and Verzulli: Waiting times and socioeconomic status among elderly Europeans: Evidence from SHARE. 2009
This study also uses the SHARE 2004 study population. Subjects were included if they had at least one appointment with a specialist or underwent elective surgery within the past 12 months. They were asked how long they had waited. There is no indication as to the point in the patient journey at which they started to wait. The total sample included 2 914 subjects after Switzerland had been excluded due to an insufficient number of participants. Sweden reported the longest waiting times for specialist appointments (10 weeks). Denmark and Spain reported 5 weeks, France, Italy and the Netherlands 3 weeks, and Germany and Greece 1 week. Reported waiting times for elective surgery averaged more than 5 months in Sweden (5.5) and Spain (5.3), 2-3 months in Austria, Denmark, France, Italy and the Netherlands, and 1 month in Germany and Greece. [40]

The Commonwealth Fund: 2010 International Health Policy Survey in Eleven Countries
The Commonwealth Fund conducts regular international studies concerning healthcare systems. In 2010, the fund carried out a telephone interview study among a random sample of more than 19,000 people age 18 and older in 11 countries; Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, Great Britain and the United States. Each country had 1,000-3,500 participants. Swiss respondents reported the fastest access to health care. Ninety-three per cent of them said that they had obtained an appointment with a nurse or doctor within one day the last time they were sick. The corresponding figure for Sweden was 57 per cent. Switzerland, Germany and the United States scored best on the variable of “rapid access to a specialist.” More than 80 per cent of the respondents in those three countries reported having waited less than four weeks for a specialist appointment. The figure for Sweden was 45 per cent. Waiting times of two months or more for a specialist appointment, or four months or more for elective surgery, were rare. Seventy per cent of the participants in New Zealand, the Netherlands and Great Britain stated that they had received an appointment with a nurse or doctor within one day. One-fourth or more of Canadians, Swedes and Norwegians had to wait at least six days. Most participants in those three countries also reported having waited at least two months for a specialist appointment.
and, like the British, at least four months for elective surgery. Whether the differences are statistically significant is not indicated, but the information is available in a technical appendix. See studies from previous years as well. [41, 42]

Kalseth B, SINTEF Helsetjensteforskning: Ventelistentatistikk i Norge, Sverige, Danmark Finland, Skotland og England - Datagrannlag og anvendelse. 2010

The report provides an overview of the data on which national waiting list and waiting time statistics are based in Norway, Sweden, Denmark, Finland, Scotland and England. It does not compare waiting list statistics, but concludes that the options for doing so are limited due to variations in the specialities and institutions that the data cover, as well as the part of the patient journey that is included and the patients who are excluded.

Assuming adequate quality assurance, it might be possible to compare waiting time from referral to surgery in Norway, Denmark, Scotland and England (Hospital Episode Statistics) for specific operations. [49]

Eurobarometer public opinion surveys are conducted by the European Commission on a regular basis. [84]

Below is an excerpt from the report Patient safety and quality of healthcare. 2010: “The most important criterion for EU citizens, when thinking about quality healthcare, is well-trained medical staff, a characteristic referred to by at least half of respondents (52%). Furthermore, 39% of respondents feel treatment that works is an important criterion for quality healthcare. Just over a quarter of respondents identify no waiting lists to get seen and treated (29%), modern medical equipment and respect of a patient’s dignity (27% for each).” [44]

Eurostat publishes data from the recurring EU Statistics on Income and Living Conditions (EU-SILC) survey that is conducted among a sample population in the EU 25 countries, Iceland and Norway (270 000 individuals in 130 000 households). EU-SILC contains a short module about health; one question asks whether the respondent has experienced an “unmet need for health care” and, if so, for what reason. Between 0 per cent (Belgium and Cyprus) and 5.4 per cent (Estonia) of all respondents reported that waiting lists were the reason for their unmet healthcare needs. At 1.8 per cent, Sweden was sixth to last (last place among the countries covered by this report). [43, 45, 47]

The Healthcare Survey is directed at the general population in Sweden. Twenty per cent (n=1466) of the respondents (autumn 2010) who did not fully agree that they had access to the health care they needed stated that shorter waiting times would improve the situation. [46]
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Swedish Waiting Times for Health Care in an International Perspective

This is the third international comparison published by SALAR. The two previous reports focused on medical outcomes and on costs. Sweden performed well in both cases, generating good results at modest costs. The previous comparisons did not examine availability, waiting times, due to difficulties in collecting suitable data.

The primary objective of this study was to determine whether waiting times for health care can be compared across various countries and whether public national statistics support the assertion that Sweden has relatively long waiting times. A secondary objective was to establish which countries measure waiting times, the methods they use and the kinds of national care guarantees they offer.

The study contributes to an increased understanding of if and how waiting times are followed up. It also gives a general picture of the health care availability in the different countries. Included countries are Sweden, Denmark, Finland, Norway, England, Scotland, Wales, Northern Ireland, Ireland, Portugal, Spain, the Netherlands, Canada, New Zealand, Australia, the United States, Austria, Italy, Greece, France, Germany, Belgium and Luxembourg.

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© Swedish Association of Local Authorities and Regions, 2011
ISBN 978-91-7164-735-1

Order or download at www.skl.se/publikationer ISBN 978-91-7164-735-1