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HEALTH SYSTEM WATCH

Aims and Scope

The aim of the quarterly is to monitor and compare healthcare systems and their performance in the European Union as well as in the accession countries, Switzerland and the United States. Health System Watch has a distinct international perspective. Each edition covers one or two topical issues from the field of health care. Furthermore it presents standardised tables which provide time series data in absolute numbers and in relation to the EU-15 / EU-27 weighted averages. The data sources for this publication are the World Health organization's Health For All Database, the Organization for Economic Cooperation and Development's (OECD) Health Data and EUROSTAT as well as the World Bank and national data. Being a quarterly, Health System Watch provides the most recent data available from international databases. The quarterly has been produced since 1999 and published in German and English: www.ihs.ac.at.

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Authors

Thomas Czypionka

Markus Kraus

Monika Riedel

Gerald Röhrling

Translations: Martina Szucsich

IHS HealthEcon

Stumpergasse 56

A-1060 Vienna, Austria

health.econ@ihs.ac.at

The Institute for Advanced Studies (IHS): <http://www.ihs.ac.at>

The IHS was funded in 1963 as a private, non-profit, independent policy oriented think tank on the initiative of Paul F. Lazarsfeld and Oskar Morgenstern with the help of the Ford Foundation, the Austrian Federal Ministry of Education and the City Council of Vienna. Since then it has combined theoretical and empirical research in economics and the social sciences with its function as a postgraduate training centre for these scientific fields.

The multi-disciplinary research group IHS HealthEcon forms part of the Department of Economics and Finance of the IHS. Being devoted to the systematic development of scientific methods and applications to public health services research, IHS HealthEcon incorporates in its research economic, demographic, epidemiological and political aspects.

Waiting times for elective operations in Austria: A question of transparency

Abstract

To analyse the complex subject of elective operations in Austria, we carried out several investigations: a poll of all hospital companies, patient advocates and the Health Ministry, an analysis of the 2006 Austrian Health Interview Survey and our own retrospective patient interviews. This enabled us to quantify waits for certain elective operations as well as their considerably uneven distribution across federal states and patients. There is far too little transparency and coordination in Austria to optimise waiting times. International examples, but also the Styrian hospital company (KAGes), demonstrate that an improvement is possible. Such a solution should be implemented Austria-wide in view of the individual and societal impact of unnecessarily long waits. There are indications that supplementary private insurance or the option of having the operation done by the respective surgeon on a private basis can shorten waiting times. Our patient interviews confirmed the practice, stated by patient advocates, that some doctors promise patients shorter waiting times if they make an out-of-pocket payment or visit their private practices. This needs to be changed as well.

Introduction

Waits for elective surgery are a serious problem in the health systems of many countries¹. In the course of an encompassing OECD study², Austria reported not to have any noteworthy waiting times for elective operations. This is contrasted by repeated reports from both patients and authorities that there are sometimes long waiting times for orthopaedic and ophthalmological operations. The objective of this contribution is to shed more light on the issue of waits for elective operations in Austria.

Approach

To obtain as detailed as possible a picture of the waiting times for planned operations in Austria, in spite of lacking and dispersed data, we performed several mutually complementary investigations. We interviewed hospital companies, patient representatives and the Health Ministry on this subject and asked them to comment on a series of questions. Further, we conducted a retrospective questionnaire-based survey of waiting times for hip and knee joint and cataract operations among patients in rehabilitation centres in Lower Austria. We also analysed the current Austrian Health Interview Survey 2006 in terms of waiting times.

¹ Cf. Cypionka T., Kraus M., Riedel M., Röhring G., Schnabl A. (2007): Waiting in Europe: An international comparison regarding elective surgery. Health System Watch I/2007, Vienna.

² Cf. Siciliani L., Hurst J.: Explaining Waiting Times Variations for Elective Surgery across OECD Countries. OECD Health Working Papers DELSA/ELSA/WD/HEA(2003)7.

Generally, we would like to point out that most of the waiting times stated below are Austria-wide average or estimated values. Deviations at individual level are therefore possible and even probable.

Waiting times from the hospital companies' point of view

As mentioned in the beginning, transparency of wait-times for planned operations and waiting criteria is basically nonexistent both in the field of orthopaedics (particularly with hip and knee operations) and ophthalmology (in particular cataract surgery). In order to give a realistic picture of the current waiting time situation in public and private non-profit hospitals in Austria, we asked all nine hospital companies, the private non-profit Vinzenz group and the private non-profit Brothers of Mercy of Austria (Barmherzige Brüder Österreich) for a statement³. They were all generally very willing to provide information. Only from two hospital companies (Lower Austria and Tyrol) we unfortunately did not receive any response.

Waiting times – how long do patients have to wait?

All hospital companies unanimously stated that waiting times for hip and knee joint as well as cataract operations existed. However, only the Styrian hospital company (KAGes) and the Upper Austrian health and hospital company (GESPAG) were able to provide an exact quantification. In KAGes hospitals the average waiting time for total hip joint endoprosthesis was 108 days (between 65 and 160 days depending on the ward), for total knee joint endoprosthesis it was 172 days (between 100 and 255 days depending on the ward) and for cataract surgery patients 142 days (between 84 and 200 days depending on the ward). In GESPAG hospitals the average waiting time for hip and knee joint operations amounts to 10.3 weeks⁴ and 21.3 weeks⁵, respectively, and for cataract operations to 12 weeks.

According to the Vienna hospital association (KAV), orthopaedics waiting times were six months at the longest (and pointed to a decrease) and in ophthalmology between two and six months. Vienna General Hospital (AKH) stated waiting times for elective hip and knee joint operations of up to six months and for elective cataract operations of three to four months. From the Tyrolean patient representation we received a statement on waits in the ophthalmology and orthopaedics university hospitals of the state hospital/university hospitals of Innsbruck. Waiting periods for orthopaedic interventions are one month for patients with general and those with additional private insurance alike. For ophthalmological operations, patients with general insurance have to wait five months, while those with additional private insurance wait two weeks. In the hospitals of the hospital company of Burgenland (KRAGES) waiting periods are several months for both surgery types. Carinthia's hospital company (KABEG) says it has cataract waiting times of three months in the hospital of

³ We asked the hospital companies the following questions:

- 1) Are there waits for hip joint, knee joint or cataract operations in the state hospitals?
- 2) If such waits exist, please quantify them.
- 3) Do you keep waiting lists of patients queuing for an operation?
- 4) According to what criteria/priorities do you rank patients waiting for surgery on the waiting lists?

⁴ Related to all wards performing elective operations.

⁵ Related to orthopaedic wards.

Klagenfurt and of 12 months in the hospital of Villach. Explaining this pronounced gap, the KABEG management said that substantial capacity increases had substantially cut waits in Klagenfurt state hospital, which seemed to be widely unknown among the public concerned and the referring specialists, however. In Vorarlberg's state hospitals short waiting times for elective operations occur occasionally, the Vorarlberg hospital company stated.

Not only public, but also private non-profit hospitals confirm waiting times for elective operations. Patients in Vinzenz group hospitals have to reckon with waits for orthopaedic operations of three months to more than a year. In the hospitals of the Brothers of Mercy, too, there are waiting periods for both types of surgery. Waits for endoprosthetic surgery last between 10 and 12 months in the hospital of Eisenstadt, compared with four to six weeks in Klagenfurt. For cataract surgery, the period is three months in the hospital of Linz and five months in Vienna.

Overall, waiting times for hip and knee joint operations (endoprosthetics) in public non-profit hospitals can be expected to last between three and six months. In certain wards of private non-profit hospitals patients may wait for such operations for up to a year and longer. We think this imbalance of waiting times is attributable, among other things, to the fact that private non-profit hospitals have specialised in certain fields and therefore attract large numbers of patients. Another reason is the reputation of individual chief physicians. This leads to longer waiting times, which the patients are prepared to accept, however. Moreover, patients seem to prefer a particular type of hospital (namely order hospitals) and are prepared to wait longer to be treated or operated on there. It also has to be borne in mind that private non-profit hospitals generally have smaller capacities than their public non-profit counterparts, which is another reason for longer waiting times. Below-average waits for orthopaedic operations can be found in the state hospital/university hospitals of Innsbruck and the Elisabethinen hospital of Klagenfurt (four weeks and four to six weeks, respectively). Waiting periods for cataract operations are between two and six months on average. Contrary to orthopaedic interventions, wait lengths are independent of the hospital type here.

Waiting lists – according to what criteria are patients ranked?

Keeping transparent, country or state-wide standardised waiting lists is not a common practice in Austria. Rather, each hospital ranks patients according to self-defined criteria. In our opinion, standardised and transparent criteria for waiting lists would therefore be highly desirable. KAGes plays a pioneering role here, having developed an ingenious, transparency-aimed, state-wide uniform waiting list management for hip and knee as well as cataract surgery.

In order to better use resources, GESPAG, e.g., keeps electronic waiting lists in wards/hospitals where waiting times exceed two weeks. Patients are ranked by medical urgency, pain symptoms, but also social factors such as active employment so as to allow individuals to resume work as soon as possible. All wards save capacities for such rather acute cases, and when planned operations are cancelled, patients on the waiting list are

served instead. In GESPAG hospitals, quite urgent operations can therefore be performed without any substantial waiting time.

The Salzburg state hospital company (SALK) books operations depending on their urgency. Medical as well as social criteria determine the length of the wait. They resemble those of GESPAG and include pain burden, invalidity, age, expected risk increase during a possible wait, active employment and work capacity, threat of job loss, comorbidity and family status. In some patients a single criterion (e.g. age over 85 years), in others the interaction of several criteria (e.g. sick leave due to pain with threat of job loss in the case of work incapacity) decides on immediate operation. SALK basically differentiates between acute and standard waiting lists.

On account of a pronounced increase in waiting times and the aim to achieve objectivity and transparency, KRAGES has launched a project to introduce electronic waiting lists that are standardised according to medical criteria. KRAGES says it has contacted KAGes to get relevant information and to be able to keep uniform cross-state waiting lists in the future. As health care structures differ considerably between Styria and Burgenland, KRAGES is currently exploring to what extent KAGes' ranking criteria and the resulting timing of operations can be applied in Burgenland.

The collected statements reveal that, aside from medical urgency, criteria like age (very old or very young) and professional necessity determine how long a patient has to wait for an operation.

In this context it has to be pointed out that in Austrian hospitals acute patients are immediately treated or operated on. The hospital companies confirmed this in their statements.

Waiting times from the point of view of patient representatives

To get a comprehensive picture of whether and to what extent waits give rise to complaints, we have asked all patient representatives for a relevant statement⁶. The level of preparedness to share information was high again, with eight out of nine patient representatives having responded to our enquiries.

Waiting times – a reason to complain?

Our evaluation showed that there was neither a west/east nor a north/south wait-time gap. There is general agreement among patient representatives that long waiting times for

⁶ We asked patient representatives the following questions:

- 1) To what extent are waits for elective operations an issue in your work as a patient representative?
- 2) If such waits exist, please quantify them.
- 3) Do you receive indications that private out-of-pocket payments and/or the visit to private practices and/or additional private insurance shorten waits for elective operations?

elective operations are frequent, in particular for orthopaedic⁷ and ophthalmological⁸ operations, but also for cardiac and neurosurgery. These waiting times repeatedly give rise to patient complaints. For the patients concerned it is often difficult to understand that their health problem does not justify immediate surgery, although hospital companies and doctors repeatedly reassure them that operations are scheduled according to medical urgency, the patient representative from Vienna explains. He also points out the psychological burden of seeing one's operation date postponed due to another patient's emergency surgery. In the context of complaints it has to be borne in mind that the acceptance of waits goes hand in hand with the level of suffering the patient experiences. With increasing suffering, the patients' preparedness to wait shrinks markedly. Accordingly, a one month wait may appear unacceptable for a patient experiencing great pain and can therefore give rise to a complaint, while a less pain-stricken patient may consider a waiting time of six months and more as unacceptable.

Only the patient representative of Vorarlberg stated that waiting times for elective surgery were not a reason of complaints, which does not imply, however, that waits do no trouble patients. Rather, he says that pain patients in particular desire speedy treatment and may therefore want to prevent waiting times from being prolonged by a complaint procedure. In our opinion a reason might also be that wait-times for elective operations are generally shorter in Vorarlberg than in other states.

Waiting times – quantification by patient advocacies

None of the patient advocates was able to exactly quantify waiting times. A reason for this may be that, as far as we know, hospitals do not have any waiting times statistics – a situation that urgently needs to be improved in order to increase transparency. The patient representative of Burgenland speaks of waits for orthopaedic operations of up to six months in certain cases. His colleague from Styria reports similar lengths (hip prosthesis, urgency level 3: around three months; knee prosthesis, urgency level 3: under six months).

The patient advocate of Carinthia considers the prevailing waiting periods of six to eight months for cataract operations as too long. He considers it unethical to leave an old person's sense organ in a bad state instead of improving it.

Supplementary private insurance to shorten waits?

“Supplementary private insurance shortens waiting times for elective operations” is a rumour that has existed for a long time. Almost all of the separately interviewed patient representatives said there were indications that patients with additional private insurance faced shorter surgery waiting times. The patient representative of Styria confirmed that supplementary private insurance shortened waits for cataract operations. According to Burgenland's patient representative, complainants/patients pointed to the fact that waiting

⁷ In this context above all hip and knee prostheses.

⁸ In this context above all cataract operations.

⁹ Cf. Cypionka T., Kraus M., Riedel M., Röhrling G., Schnabl A. (2007): Waiting in Europe: An international comparison regarding elective surgery. Health System Watch I/2007, Vienna.

periods for operations were shorter for those with additional private health insurance. These reproaches, however, concerned hospitals in other federal states. The correctness of these statements could not be verified. In an interview with us, the patient representative for Lower Austria confirmed complaints about the practice of raising patients' hopes of jumping the queue by making out-of-pocket payments. When patient advocacies enquired, it was always denied that patients had been suggested that. In this context, Vienna's patient representative points to the fact that insurance companies advertise supplementary private insurances by "short waiting times for operations" on their websites. Uniqa, e.g., advertises its additional medical insurance among other things by the slogan of "fast and flexible booking of treatment and operation appointments"¹⁰, and Wiener Städtische promises that "you will be served by a doctor you trust and get earlier appointments"¹¹.

This preferential treatment of patients with additional insurance can be attributed to two causes: Firstly, orthopaedic and ophthalmologic operations of patients with supplementary private insurance are often performed in general practitioners' or private hospitals. Such hospitals are often able to offer early appointments for operations since they do not have to treat any emergency cases. This facilitates the planning of hospitalisation and surgery. Earlier appointments for private medical insurance holders for these reasons do not constitute a problem. Secondly, public hospitals can make surgery appointments only depending on bed availability. Normally, special category beds, i.e. beds for patients with private health insurance, are rather available or easier to reserve than general beds. As additional private health insurance, which entitles patients to such upgraded rooms in public hospitals, covers mainly accommodation and physicians' fees, but not preferential treatment in making surgery appointments, the latter practice would be dubious¹². Rather, it would be necessary to distribute bed capacities so as to prevent preferential treatment. Otherwise it would mean that patients with the same medical needs would be treated unequally by public hospitals. This debate is also relevant with regard to special charges, since the number of special class beds must not exceed a certain percentage of all beds¹³.

Waiting times from the Health Ministry's point of view

In the course of this investigation we also asked the Health Ministry for a statement on the problem of waiting times for elective operations. In the view of the Ministry, there are no substantial waits for elective operations in Austria. Waiting times occurred occasionally with planned operations, the Ministry said.

Austria-wide, waits for orthopaedic and ophthalmologic operations are largely tolerable, though not desirable, both from a medical and the patients' point of view. This seems to be

¹⁰ URL: http://www.uniqa.at/uniqa_at/cms/privat/health/special_class/index.jsp, accessed on October 17, 2007.

¹¹ URL: <http://www.wienerstaedtsche.at/privat/gesundheit/produktuebersicht/sonderklasse-versicherung>, accessed on October 17, 2007.

¹² Cf. also footnote 14.

¹³ See report of the Court of Audit 2006/12.

the reason why the Ministry refers to the waiting times for elective operations as not substantial.

The question that arose for us was whether the Ministry currently surveyed waiting times for elective operations or would do so in the future. At present, the Ministry is not taking any initiative to investigate waiting times. The only activity worth mentioning was the investigation, conducted as part of the last health interview survey, of waiting times for five selected elective operations. In the future the Ministry will have to collect waiting time information for planned operations in the framework of Europe-wide valid indicators¹⁴.

Changes have to be made here, also in view of the Health Services Quality Act.

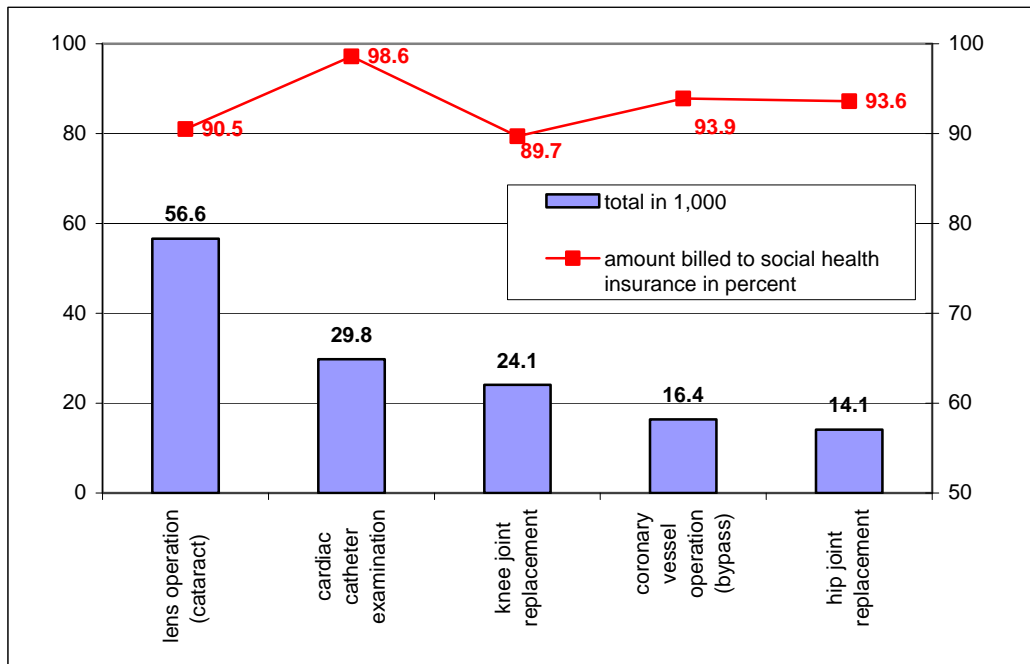
Waiting times in the light of the Austrian Health Interview Survey

In the course of the recently published 2006 Austrian Health Interview Survey¹⁵, the attempt was made for the first time to investigate the current situation of waiting times for selected elective operations from the patients' point of view. The complex of questions pertaining to waiting lists is part of the European Health Care Module – EHCM, section “inpatient stays” – and comprises three questions. At the beginning, interviewees are asked whether they had an elective operation in the past 12 months. The focus was on the following five operations: Lens surgery (to treat cataract), hip joint replacement, knee joint replacement, coronary vessel operations (bypass) and cardiac catheter examinations. Then the interviewees were asked to indicate how long (in days, weeks, months) they had to wait for the operation and finally to state whether the operation was billed to the social health fund or a private health insurance¹⁶.

¹⁴ One of the objectives of the European Commission is to collect comparable data on the population's health and health-related behaviour, diseases and health systems. To define, collect and use these data, it applies uniform European indicators. One of these indicators covers waiting times for elective operations.

¹⁵ The survey was commissioned by the Federal Ministry of Health, Family and Youth (BMGFJ) and the Federal Health Agency and developed and performed by Statistics Austria. It provides representative statements for the Austrian population aged 15 and over. Cf. BMGFJ, Statistik Austria: Österreichische Gesundheitsbefragung 2006/2007: Hauptergebnisse und methodische Dokumentation. Vienna, 2007.

¹⁶ Hospital owners (public – private non-profit – private for-profit) were not included – but should be considered in the next health survey.

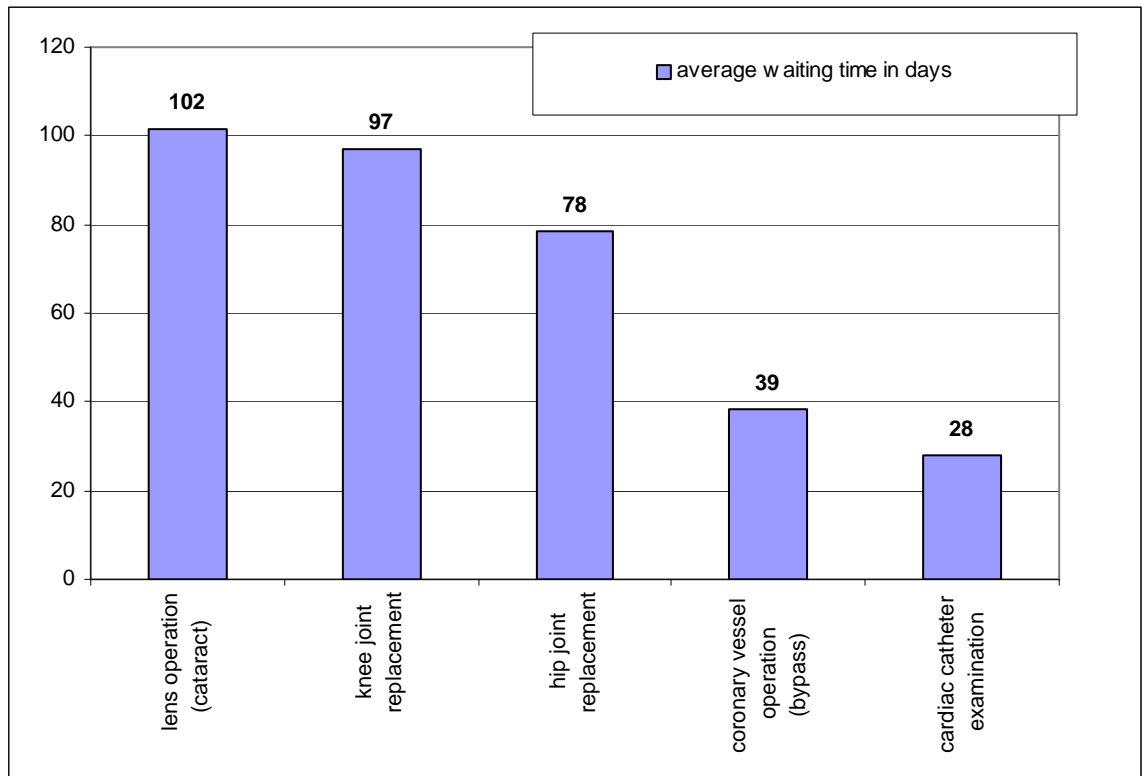
Figure 1: Persons having had the respective planned operation in the past 12 months

Source: Statistics Austria 2007, IHS HealthEcon 2007.

With slightly under 57,000 operations, eye lens surgery (to treat cataract) has been the most frequent elective operation in the past 12 months, cf. figure 5. Around 24,000 individuals underwent knee joint and at least 14,000 hip joint surgery. The majority of all five surgery types, namely between 89.7 and 98.6 percent of all operations, was billed to social health insurance.

The results of the health interview survey show that there are partly considerable waiting periods for the selected elective operations in Austria. According to the survey, cataract patients wait longest, namely on average 102 days, for lens surgery, cf. figure 5. Hospital companies indicated waiting times for this operation of between two and six months. As for hip and knee joint operations, the waiting times stated in the health interview survey (97 and 78 days, respectively) are clearly below the periods stated by the hospital companies (three to six months). However, waits for hip and knee joint operations are a problem, in particular because they generally mean prolonged periods of pain and reduced quality of life due to restricted mobility. Waiting times are generally shorter if a private health insurance company is billed for the operation. Patients with only statutory health insurance wait on average four times longer than privately insured patients for cataract operations, 3.5 times longer for knee operations and twice as long for hip surgery and cardiac catheter examinations¹⁷. As it is impossible to differentiate between hospital owners in this context, it remains unknown whether this is also the case for public hospitals.

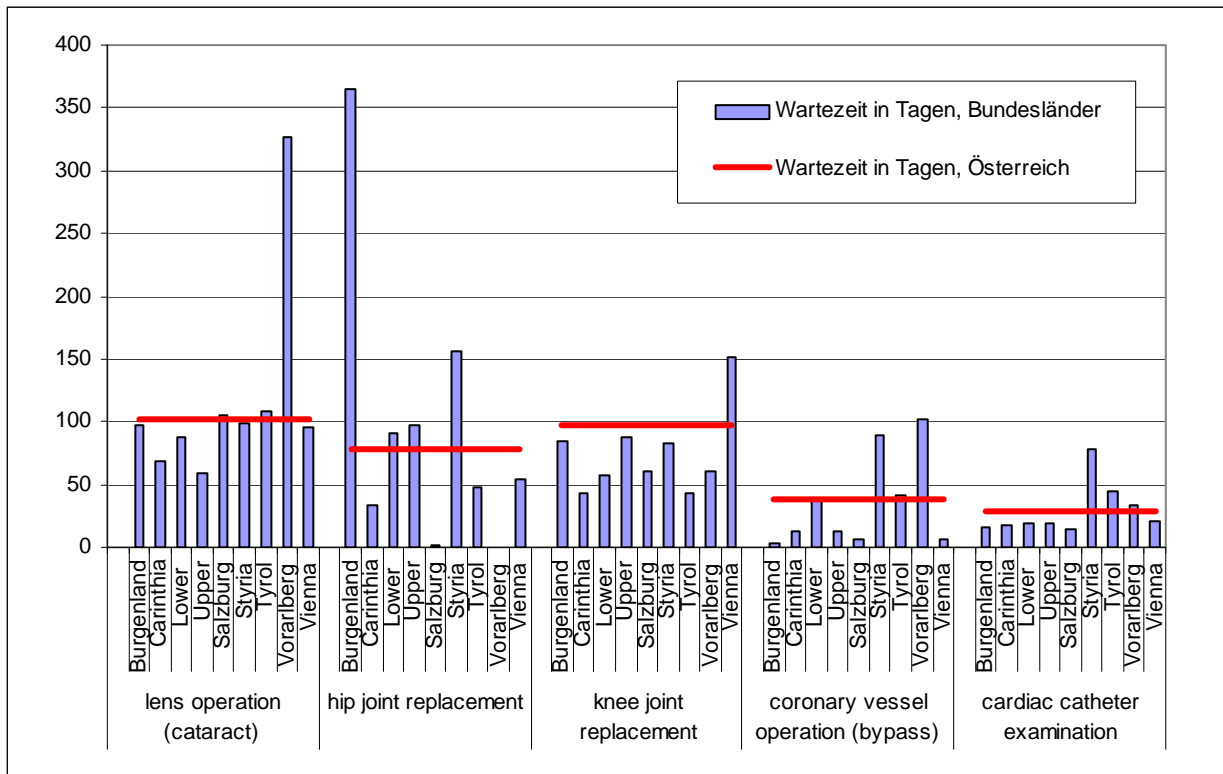
¹⁷ BMGFJ, Statistics Austria: op.cit..

Figure 2: "How long did you have to wait for your operation?"

Source: Statistics Austria 2007, IHS HealthEcon 2007.

A gender and age specific view reveals partly surprising and not easily explainable differences in average waiting times, cf. annex table A1: The widest gender gaps were found with lens and knee joint operations. Men wait more than a month longer than women for cataract surgery; in the case of knee surgery, in turn, women wait almost a month longer. As for the other operations, men wait seven to 16 days longer than women do. It is also surprising that, when looking at the two major age groups (15-60 years and older than 60 years), the two orthopaedic operations show different trends regarding waiting times: While the largely retired population over 60 years waits for hip joint surgery on average three quarters longer than the actively employed population, their waiting time for knee joint operations is almost 60 percent shorter than the period persons aged 15-60 have to wait. There is no apparent relation between the number of operations performed and the waiting time: As mentioned, waiting times for hip joint operations, which occur almost twice as often among people aged over 60 years, increase by 75 percent. Waits for knee joint operations, in turn, are shorter among the retired population despite much higher surgery frequencies (nearly 50 percent more operations) as compared to those aged 15-60.

Figure 3: Waiting times by federal state



Source: Statistics Austria 2007, IHS HealthEcon 2007.

A comparison of waiting times between the federal states shows that Styria, e.g., is clearly above the Austrian average regarding three out of five elective operations (hip joint replacement: waiting time twice as long as the country-wide average; bypass surgery: 2.3 times the average; cardiac catheter examination: 2.8 times the average wait). Extreme upper outliers can also be found in Burgenland (hip joint operations: waits of about a year), Vorarlberg (cataract operations: more than 3 times the Austrian average waiting period) and Vienna (knee joint replacement: around 1.5 times longer than average waits in Austria).

One of the reasons for the remarkable wait-time gaps between the federal states is that, due to the existing financing system, available or free capacities are not balanced across the states.

Waiting times in the light of a patient poll

Thanks to the support from the Austrian social security institutions, IHS was able to improve Austria's data on waiting times for elective operations (hip joint, knee joint and cataract surgery) by anonymous patient interviews in the course of this contribution. Patients of three rehabilitation centres in Lower Austria were recruited for structured interviews (n=61). They were asked how long they had to wait from the decision for until the performance of the operation, whether the surgery took place in a public or private hospital, whether they had supplementary private insurance and whether the operation was postponed once or several times (by themselves or by the hospital). Further, the attempt was made to find out whether it happens in Austria that patients are offered to shorten their waiting times by private out-of-pocket payments or the visit to a private practice. The patients' state of pain and its development as well as their physical impairment and its development during the waiting period were also considered in the questionnaire.

The average waiting time for hip joint replacement is 10 weeks and for knee joint operations 29 weeks (excluding patients who postponed their operation themselves). The difference is statistically significant. As the sample contains outliers in the upper end of the distributions, the median wait-time¹⁸ for hip joint operations is reduced to six weeks (-4 weeks) and for knee joint operations to 16 weeks (13 weeks less). Across all operation types as well as for hip joint and knee operations separately, there is no statistically significant waiting time difference between the three rehabilitation centres. It was, however, quite surprising that eight percent of the interviewees stated that they had been offered to cut their wait by private co-payments. Another 15 percent said they had been suggested visiting a private practice in order to have the operation earlier. The majority of the interviewees (95 percent) suffered pain during the waiting period. Three quarters said they had severe or very severe pain and in around 40 percent of the patients the pain increased during the wait. Almost 97 percent of those questioned felt physically impaired; around two thirds classified this impairment as severe or very severe, and slightly more than half the interviewees said this impairment increased over the waiting time. The average age of patients undergoing hip joint surgery was 73 years, of those undergoing knee joint surgery it was 66 years. There was no statistically significant relation between age and waiting time. Due to the insufficient numbers of operations in private hospitals, patients with supplementary insurance and men, an evaluation in terms of hospital type, additional insurance and gender was not possible.

¹⁸ The median as an outlier-independent location parameter divides the sample in two, with 50 percent of the values above and 50 percent below the median.

Due to the small sample, the results of the poll are to be understood as indications/guidelines and should not be over-interpreted. However, there are plans to expand the survey, which is currently limited for time and cost reasons, in order to enable more detailed and more representative statistical analyses.

Overall, the retrospective view confirmed the existence of waiting times and their considerable inter-individual variability just as the existence of isolated cases of patients waiting extremely long without having postponed the operation themselves. Further, the relatively high occurrence of offers to shorten waits by out-of-pocket payments or visits to private practices is disturbing.

Waiting times from the point of view of transparency

There is practically no transparency of waiting times for elective interventions in the Austrian health care system. Transparent and understandable criteria according to which patients are ranked on waiting lists are lacking as well. When looking beyond national borders, e.g. to Great Britain and Canada, there are ways to make waiting times for elective surgery more transparent.

The website of the UK Department of Health¹⁹, e.g., publishes, on a quarterly basis, the numbers of patients per county waiting for a certain operation and the duration of the waits. Apart from that, information on waiting times for magnetic resonance imaging, computerized tomography, gastroscopy and colonoscopy is provided. This makes it easy for patients to inform themselves about waiting times in hospitals in their neighbourhood.

On its website²⁰, Health Canada offers a wealth of information about waiting times for all common operations as well as for CT and MRI scans separately for each province. For each type of surgery, this comprises

- information on the target waiting time²¹,
- information on the number of waiting patients,
- information on the average and median waiting time,
- information on the waiting time in the selected hospital,
- information on the waiting time with the selected surgeon,
- a deviation analysis regarding target and actual waiting time.

The information is presented in patient-friendly graphs and tables, following the same scheme for all operations. Taking the example of hip surgery, we present a part of the accessible/available waiting time information material for the province of Alberta (Canada).

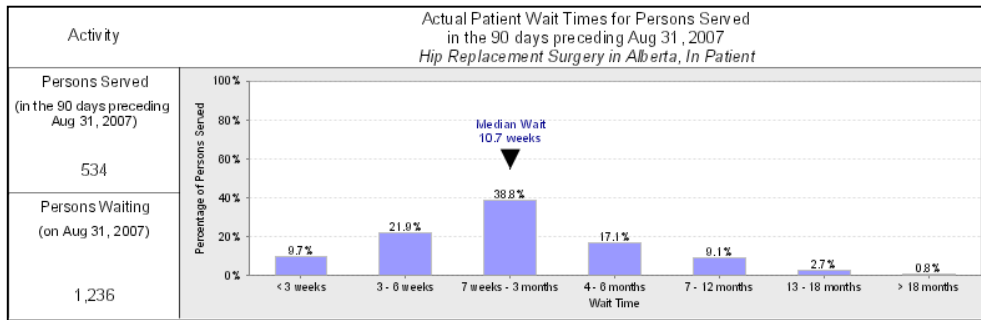
¹⁹ Homepage of the Department of Health: www.doh.gov.uk.

²⁰ Homepage of Health Canada: www.hc-sc.gc.ca.

²¹ The province of Alberta has defined a target wait-time for each surgery type according to medical urgency. 90 percent of all waiting patients are to be operated on within this target period.

Charts like the one shown in figure 4 inform patients on the median wait time, the number of waiting patients and the number of patients who underwent surgery in the preceding 90 days. As patients can easily see in this figure, the median wait for hip replacement as of 31 August, 2007 is 10.7 weeks. 1,236 patients wait for such an operation. The diagram also demonstrates that 70.4 percent of the waiting weeks are operated on within three months.

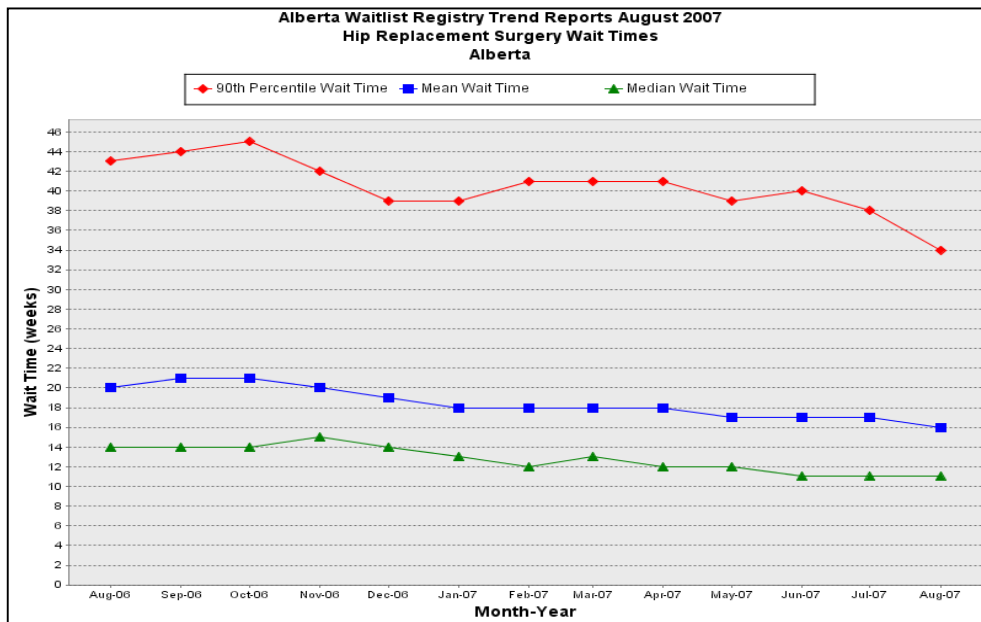
Figure 4: Waiting time for hip replacement in the province of Alberta



Source: Health Canada, accessed on October 9, 2007.

As charts like the one in figure 5 show, waits for hip replacement surgery are decreasing. The average waiting time has declined to 16 from 20 weeks in a year-to-year comparison, and the median wait time has decreased to 11 weeks, down from 14.

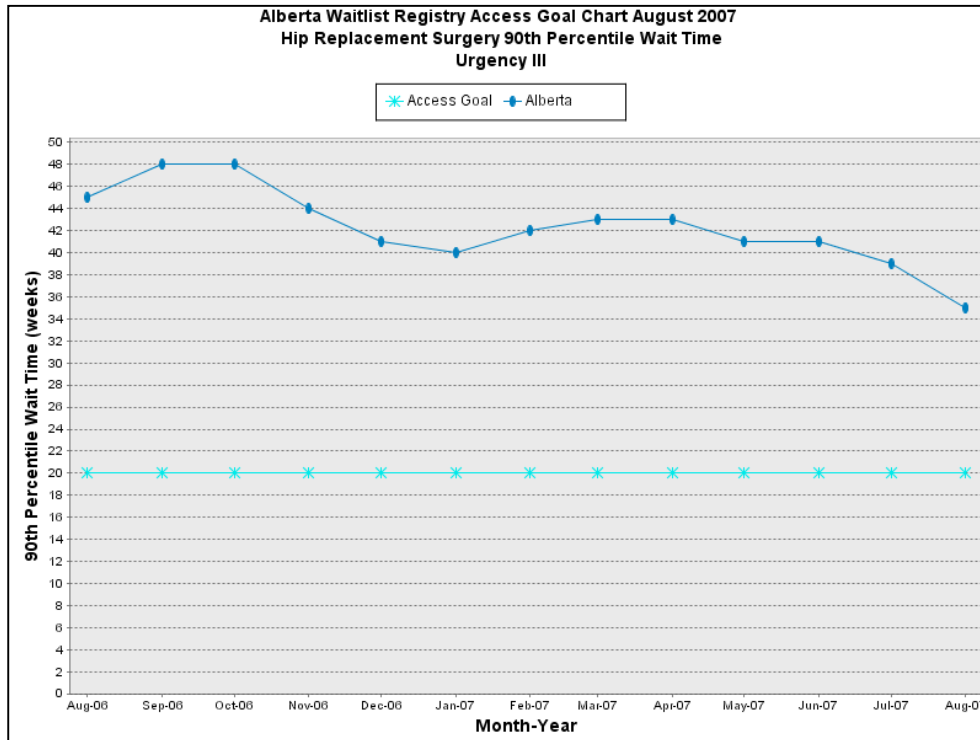
Figure 5: Waiting time trend for hip replacement surgery in the province of Alberta



Source: Health Canada, accessed on October 9, 2007.

Charts like figure 6 reflect that actual wait-times differ considerably from planned waiting periods. In the province of Alberta, the target wait-time for hip surgery (urgency level 3) amounts to 20 weeks, while the actual wait is about 34 weeks.

Figure 6: Target and actual waiting times for hip replacement in the province of Alberta



Source: Health Canada, accessed on October 9, 2007.

In Canada, elective operation waitlists are fully transparent down to hospital and even surgeon level. This transparency of waiting times and waitlist management as a whole serves as a showcase for Austria. In order to keep such transparent waiting lists and offer them to patients in Austria, too, all stakeholders in health care would have to enhance their preparedness for transparency. This has not happened yet, however.

Transparency of waiting times following the Canadian example would be very helpful for patients and physicians alike. It would enable both sides to get a comprehensive picture of the wait-time situation. When knowing the length of waits, physicians could, e.g., refer patients to hospitals with short waiting times. Patients would have the opportunity to make appointments for operations in hospitals with short waiting times.

The current imbalance of waits for cataract surgery in KABEG hospitals (see above) is an example of lacking transparency. If knowing the exact waiting periods, the referring doctors could adopt a steering role by referring more patients to Klagenfurt hospital until equilibrium is achieved.

Waiting list management in Styria – a step into the right direction

In 2004, in the framework of safeguarding adequate patient care, the then newly elected board of KAGes took up the subject of waiting times. This was preceded by increased media coverage of the problem of long waits for planned operations. Together with the hospitals and wards concerned, a consensus was reached on an approach to guarantee the timely provision of large joint replacement and cataract surgery. The resulting waiting list management aims at a systematic analysis of waits in order to be able to detect care deficits in good time. In the meantime, KAGes hospitals have adopted a pioneer role as far as waiting list management is concerned.

In the following we describe the KAGes' waiting list management. Its centrepiece is a **level-based system to prioritise** elective operations. The waiting patients are ranked mainly by medical criteria (cf. figure 7). For each urgency level, "acceptable" waiting times are defined as target values. By implementing this system for total hip and knee arthroplasty as well as cataract operations, a KAGes-wide uniform waitlist management instrument was created.

This management system also serves for **waiting time monitoring** purposes. To be able to react to possible wait-time increases even earlier in the future, KAGes collects biannual statistics of the currently scheduled appointments and the average wait-times in the previous half year (at least for the lowest urgency level).

A prototype of an EDP tool for electronically aided waiting list management has been developed. It is now being pilot tested at the Graz university hospital of ophthalmology.

As far as we know, there is no such transparent waiting list management in any other federal state. It is more than desirable that more hospital companies follow the Styrian example and thereby cast light on the waiting times for elective operations.

Figure 7: Urgency level-based system to prioritise elective operations

Urgency level	Total hip / knee arthroplasty
level 0 (acute) 24 hours	fracture <hr/> OR existing total endoprosthesis AND - prosthesis dislocation OR - acute prosthesis infection
level 1 (elective) urgent up to 6 weeks	arthrosis (including rheumatoid arthritis, necrosis of the femoral head) AND - actively employed AND - continuous analgesics (joint related) OR - ability to walk only with a stick (joint related) OR - WOMAC score ¹ function > 110 pain > 30 <hr/> OR existing total endoprosthesis AND - clinically manifest loosening of the prosthesis OR - recurrent dislocation (hip) / major instability (knee) OR - chronic prosthesis infection <hr/> OR spacer replacement ²
level 2 (elective) semi urgent up to 3 months	arthrosis (including rheumatoid arthritis, necrosis of the femoral head) AND - chronic – permanent pain (joint related) OR - regular, but not continuous analgesics OR - WOMAC score function > 35 pain > 10 <hr/> OR existing total endoprosthesis AND - radiologically manifest loosening OR - wear of bearing couples
level 3 (elective) not urgent up to 6 months	arthrosis (including rheumatoid arthritis, necrosis of the femoral head) AND - chronic recurrent pain (joint related) OR - occasional analgesics OR - WOMAC score function < 35 pain < 10

Source: Styrian hospital company ltd.

Notes:

¹ Index that determines pain, stiffness and the so-called functional capacity of patients with arthrosis of the hip and knee joints at several measurement levels.

² Spacers are special types of endoprotheses.

Conclusion

Interviews with hospital companies, the Health Interview Survey and our own patient polls confirmed the existence of waits for elective operations and allowed their quantification. There are large gaps not only regarding the operation type, although with orthopaedic operations – knee and hip arthroplasty – the same capacities can be used interchangeably. Large gaps can also be found between and within federal states, which cannot solely be explained by regional variations in demand and lacking preparedness to travel. Rather, we attribute this situation partly to lacking transparency of waiting times. As the poll among hospital companies has revealed, the consequence is that specialists and patients do not even know the length of waits in a particular hospital. It would be in the interest of the patients to give them the option to choose a hospital further away from their home. A precondition for this is to think beyond state borders, as there are partly remarkable gaps between the federal states. Thinking in terms of the zones of the Austrian health structure plan instead of federal states would mean some progress, but in view of Austria's size still not the optimum. In this context, aside from cross-state planning, the problem of guest patients could finally be solved in the insured persons' interest. The poll among rehabilitation centres clearly proves that some individuals heavily miss out due to this problem and that extremely long waits occur in some cases.

There are clear indications that patients with supplementary private medical insurance enjoy preferential treatment. However, as the hospital ownership type is unfortunately not considered in the health interview survey, this cannot be confirmed for public hospitals. Our own survey does consider the type, but the sample is not large enough to establish a correlation.

Indications that patients are offered co-payment or private practice visits to shorten waits, however, were confirmed in our interviews. No less than 8 percent and 15 percent, respectively, of the patients we interviewed were offered these options. The medical community, the Health Ministry and the state governments are called to take measures against this practice.

In view of the large dispersions, unnecessary waits caused by lacking transparency and coordination are likely to be enormous. Human capital is thereby lost and individual suffering prolonged. International examples demonstrate that transparency and coordination are possible. The hospital company of Styria has set a good example of how to implement such a waitlist management. In view of what has been said there is urgent need for action to apply such a model in and for the whole of Austria.

Table A1: Operations and waiting times in Austria, by age group and gender

	lens		hip joint		knee joint		coronary		cardiac	
	operations in 1,000 ¹⁾	waiting time in days	operations in 1,000	waiting time in days	operations in 1,000	waiting time in days	operations in 1,000	waiting time in days	operations in 1,000	waiting time in days
Total	56,6	102	14,1	78	24,1	97	16,4	39	29,8	28
15-60	9,6	42	4,8	52	9,8	147	5,6	54	12,3	37
15-30	1,0	27	-	-	1,9	61	-	-	0,3	14
30-45	2,4	31	0,8	81	1,2	150	1,7	38	3,2	24
45-60	6,2	49	4,0	47	6,7	171	4,0	61	8,8	42
60+	47,0	114	9,3	92	14,3	63	10,8	30	17,5	22
60-75	20,5	106	5,2	123	7,4	72	6,0	21	10,8	26
75+	26,6	120	4,0	51	6,9	52	4,8	43	6,8	17
Men	20,9	123	6,6	87	7,1	77	11,1	41	16,7	32
15-60	3,0	20	2,7	46	3,1	96	4,9	62	8,0	49
15-30	0,6	1	-	-	1,9	61	-	-	-	-
30-45	0,8	12	0,5	91	1,2	150	1,5	42	1,2	49
45-60	1,6	32	2,2	35	-	-	3,4	71	6,8	49
60+	17,9	140	3,9	115	4,0	61	6,2	24	8,7	17
60-75	7,9	151	3,2	134	2,6	84	4,1	12	6,0	18
75+	10,0	132	0,7	30	1,5	22	2,1	48	2,7	14
Women	35,7	89	7,5	71	17,0	105	5,4	34	13,1	23
15-60	6,6	52	2,1	61	6,7	171	0,8	3	4,3	13
15-30	0,5	61	-	-	-	-	-	-	0,3	14
30-45	1,6	42	0,3	61	-	-	0,2	3	2,0	10
45-60	4,6	55	1,8	61	6,7	171	0,6	3	2,0	16
60+	29,1	98	5,3	75	10,3	63	4,6	39	8,8	27
60-75	12,6	78	2,1	107	4,8	66	1,9	39	4,8	35
75+	16,5	113	3,3	55	5,5	60	2,7	39	4,0	18

¹⁾ The value regards persons who answered the question "Have you had a planned operation in the past twelve months" with "yes" and who said they had lens surgery (due to cataract).

Source: Statistics Austria, Austrian health interview survey 2006/2007.

Table A2: Interventions per 100,000 inhabitants

	hip prostheses (inpatient)				knee prostheses (inpatient)				cataract operations (inpatient)				cataract operations (conducted by day clinics)			
	1995	2005	1995 =100	EU2005= 100	1995	2005	1995 =100	EU2005= 100	1995	2005	1995 =100	EU2005= 100	1995	2005	1995 =100	EU2005=100
Austria	206 ^{uj}	270	131	187	94 ^{uj}	187	198	192	465 ^{uj}	698	150	304	n.a.	n.a.	n.a.	n.a.
Belgium	162	217 ^{aj}	134	150	86 ^{uj}	137 ^{aj}	159	140	553	164 ^{aj}	30	71	743 ^{uj}	1436 ^{aj}	193	251
Bulgaria	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Denmark	125	194	155	134	48 ^{uj}	106	221	109	133 ^{uj}	20	15	9	222 ^{uj}	502	226	88
Germany	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Estonia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Finland	110	183	166	127	64	168	261	172	305	30	10	13	153	765	501	134
France	174 ^{uj}	187 ^{uj}	107	129	71 ^{uj}	85 ^{uj}	120	87	507 ^{uj}	482 ^{uj}	95	210	118 ^{uj}	270 ^{uj}	228	47
Greece	34 ^{uj}	61 ^{uj}	182	42	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Ireland	110	127	116	88	16	40	253	41	316	111	35	49	39	140	361	24
Italy	92 ^{uj}	139 ^{aj}	152	96	18 ^{uj}	73 ^{aj}	412	75	340 ^{uj}	164 ^{aj}	48	72	21 ^{uj}	583 ^{aj}	2843	102
Latvia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Lithuania	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Luxembourg	169 ^{uj}	213	126	148	94 ^{uj}	151	160	155	481 ^{uj}	635	132	277	185 ^{uj}	314	170	55
Malta	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Netherlands	156	199	127	138	61	131	216	134	274	25	9	11	116	737	635	129
Poland	n.a.	33	n.a.	23	n.a.	n.a.	n.a.	n.a.	n.a.	304	n.a.	133	n.a.	n.a.	n.a.	n.a.
Portugal	50	77	154	54	6	24	430	25	100	135	135	59	n.a.	153	n.a.	27
Romania	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Sweden	151 ^{uj}	208	138	144	74 ^{uj}	108	146	111	34 ^{uj}	20	60	9	615 ^{uj}	872 ^{uj}	142	152
Slovakia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Slovenia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Spain	70 ^{uj}	90	129	62	33 ^{uj}	92	277	95	363 ^{uj}	102	28	44	n.a.	893	n.a.	156
Czech Republic	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	332 ^{uj}	411	124	179	n.a.	n.a.	n.a.	n.a.
Hungary	70 ^{uj}	118	169	82	n.a.	55	n.a.	56	n.a.	827	n.a.	360	n.a.	3	n.a.	1
United Kingdom	134	186	139	129	59	125	210	128	196	43	22	19	142	584	411	102
Cyprus	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
EU (available countries)*	121	144	120	100	50	98	197	100	333	230	69	100	143	572	399	100
Croatia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Macedonia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Turkey	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Switzerland	n.a.	218	n.a.	151	n.a.	148	n.a.	151	226 ^{uj}	112	50	49	251 ^{uj}	317	126	55
USA	98	177 ^{aj}	181	123	88	176 ^{aj}	200	181	7	3 ^{aj}	49	1	n.a.	n.a.	n.a.	n.a.

*population-weighted

^{aj}2004, ^{uj}2003, ^{vj}2002, ^{wj}2001, ^{xj}2000, ^{yj}1999, ^{zj}1998, ^{1j}1997, ^{2j}1996

Source: OECD Health Data, July 2007, IHS HealthEcon calculations 2007.

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