Waiting for Elective Surgery

The existence of waiting times for elective surgery is a fact of life in many industrialised countries. Often waiting times are so long that they constitute a cause for political concern. In several countries long and even growing waiting times have been evident for many years. By contrast, there is a number of countries where waiting times do not play a major role (Table 1).

Until recently, the empirical basis of an assessment of the roots and effects of waiting times was weak because there were no truly country-comparative data. The data had to be compiled from different publications of countries, as has been done e.g. in Osterkamp, 2002. It is only since 2004 that this situation has changed. Now we have the results of the OECD Health Project, a part of which is focussed on waiting times. The data have been gathered by questionnaires. But even now, more or less comparative data only exist for nine countries, some of which report only either mean or median values (Table 2). The economically and politically more relevant value is the median. The mean values tend to be somewhat higher, sometimes very much higher than the median due to a skewed distribution. Unfortunately – from an economic- and health-policy perspective – Japan is again not covered by figures on surgery (also missing in the OECD database Health Data). The country also seems not to have responded to the OECD questionnaire of the OECD Health Project, but is treated there as "not reporting waiting times".

Table 1

Waiting and not waiting for elective surgery

Waiting time	Countries
Yes (14)	Australia, Canada, Denmark, Finland, Greece, Ireland, Italy, New Zealand, Netherlands, Norway, Portugal, Spain, Sweden, UK
No (7)	Austria, Belgium, Germany, France, Luxembourg, Switzerland, USA

Note: Information is for 1999; Japan: missing information.

Source: Osterkamp (2002).

Table 2

Inpatient waiting times by surgical procedure, 2000
in number of days, median value

	Hip replacement	Knee replacement	Cataract surgery	Varicose veins	Hysterectomy	Cholesystectomy
Australia	98	120	120	94	28	48
Canada[a)]	112	136	80	n.a.	n.a.	n.a.
Denmark	87	90	36	69	n.a.	57
Finland	148	202	189	155	70	90
Norway	99	132	28	110	37	63
Netherlands[a)]	96	85	111	107	61	71
Spain[b)]	123	148	104	117	102	107
Sweden[b)]	n.a.	n.a.	199	n.a.	n.a.	n.a.
UK	211	261	182	178	110	97

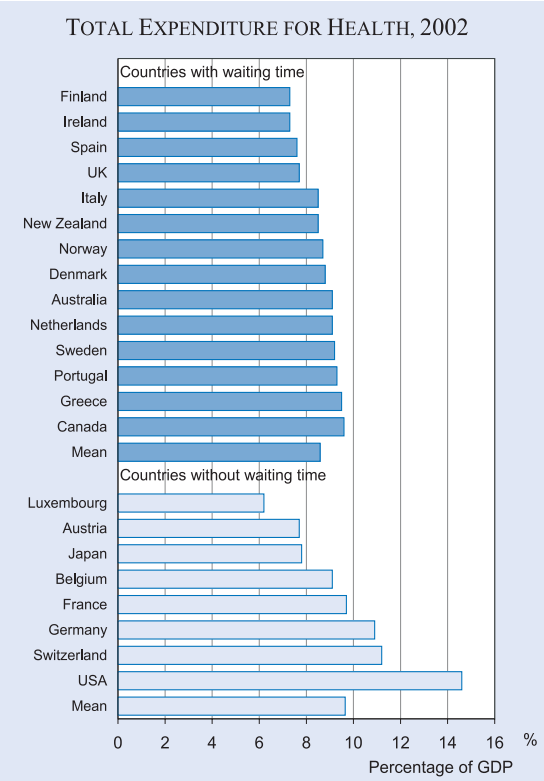
[a)] for the province of British Columbia. – [b)] mean instead of median value.

Source: OECD (2004).

The length of the waiting time is considerable in some countries and for some illnesses. According to Table 2 the majority of patients has to wait for a quarter, even for three quarters of a year. In certain individual cases the waiting time is even still longer. However, it should be noted that the figures relate to *elective* surgery, i.e. to not urgently necessary, life-saving surgery.

On general economic theory grounds, it is plausible that two main interacting causes are responsible for long waiting times: One is supply restriction and the other is no or low co-payments for surgery. Relatively strong supply restrictions are at work in countries with a high tax financing ratio of health-care costs (as opposed to financing through social security contributions). Spain is the only country with considerable waiting times and a *low* tax financing ratio. Moreover, countries with waiting lists spend relatively less for health care (see Figure) and are often characterised by a low level of co-payments. Most countries with waiting lists use general practitioners as "gatekeepers" for directing patients to specialist treatment and to surgical operations. However, it is more plausible to regard gatekeepers as a response to scarce treatment resources rather than as their cause.

Waiting times have the effect of rationing. The question is why that effect is not produced by the "normal" rationing instrument, the price. The usual answer by health politicians and public health economists refers to undesirable distributional effects (not treated by the OECD) of price-rationing. However, it is



Source: OECD Health Data 2004.

not easy to avoid these effects completely. In the UK, for example, patients are allowed to circumvent the waiting queue and have their surgery done in private clinics – for extra ("out of pocket") payment. Health treatment, thus, is more unequally distributed than it would be without this option. On the other hand, the private patients cannot avoid paying their share of the general health-care system through (progressive) income taxes. Norway, by contrast, is more consistent on the distributional question. Circumventing the queue is only possible by way of surgery *abroad*, not in Norway.

Waiting times must also be seen under the aspect of allocation. Forced waiting might be an effective instrument of rationing but it is hardly an efficient one. One reason is that the administration of waiting queues is costly. "Administration" here means continuous checking and re-checking of the health condition of the patients on the waiting list and of "prioritising" them, i.e. of placing them forward and backward on the list according to their changing health condition, relative to other patients. Thus, a major part of administering the waiting list must be done by the same health personnel that could also do surgery. The effect is that waiting lists, to a certain degree, feed themselves and are, thus, only a second-best instrument.

On the other hand, countries without waiting lists spend, on average, a clearly higher share of GDP on their health systems. The OECD estimates that it costs two additional percentage points of GDP to move from long to short waiting lists. Low or no waiting time countries conduct also more – for some types of surgery, much more – elective surgery operations per 100,000 inhabitants and per year, without exhibiting a significant effect on the health situation of the population. Hence, a health-care design package consisting of a parsimonious tax financing plus waiting lists (if not too long and not growing) might be regarded as a fairly good solution.

R.O.

References

OECD (2004), *The OECD Health Project: Towards High-Performing Health Systems*, specifically ch. 6: Tackling Excessive Waiting Times for Elective Surgery, Paris.

Osterkamp, R. (2002), "Warten auf Operationen – ein internationaler Vergleich", *ifo Schnelldienst*, 55/10.