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Health Care Waiting List Initiatives in Sweden

by Ragnar Lofgren

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Waiting for Health Care in Sweden

In Sweden, much effort is going toward increasing people's knowledge about expected and actual waiting times for surgical services, and to reducing those waiting times. This paper has been written with the assistance of Marianne Hanning, who is the project leader of "Väntetider i Vården," or "Health care waiting times."

National initiatives to reduce health care waiting lists and waiting times in Sweden from 1987-1997

In Sweden, excessive waiting times for elective surgery have been a persistent and much-debated problem for many years. Between 1987 and 1997, four different national policy approaches attempted to reduce waiting lists and thereby improve the quality of health services in Sweden:

- Beginning in 1987 and continuing to 1989, the state and the Federation of County Councils agreed to compensate hospitals if they worked overtime to provide additional coronary artery bypass surgeries, hip replacements, and cataract surgeries. An evaluation of this initiative showed that this approach only affected waiting times marginally.
- In 1989, a new agreement was formulated to increase accessibility and capacity by comparing resources, output, and performance for all hospital departments in six specialities: cardiology, ophthalmology, gynaecology, orthopaedics, urology, and surgery. This agreement financed local projects aimed at eliminating bottlenecks or other throughput problems. The impact of this approach on waiting times is unclear, but the comparisons showed that the waiting times varied between hospitals and they remained long for certain procedures.

- In 1991, the government and the Federation of County Councils agreed upon a maximum waiting-time guarantee. The agreement stated that patients who had been waiting on a list for any of 12 different procedures was to be offered treatment within three months. If the hospital could not offer treatment within this time, the patient had a right to be treated in another hospital, or by a private clinic, at the home hospital's expense. The original guarantee agreement was in force from 1992 to 1996, and even though county council participation was optional, all the counties accepted the agreement.

A national evaluation showed that initially, the policy was a successful way of coming to terms with long waiting times. However, after two years the waiting lists started to increase, and when the guarantee was abandoned in December 1996, the waiting lists had reached the same level as when the guarantee was introduced. Figure 1 shows the development for one of the treatments—cataract surgery.

- In 1996, the maximum waiting time was "re-designed" to focus more on patients' first contact with GPs, and outpatient visits to specialists in secondary care. In 1997, the national agreement for a waiting time guarantee was limited to a guarantee for waiting times for these contacts. No long-term evaluation of the new maximum waiting-time guarantee has been conducted.

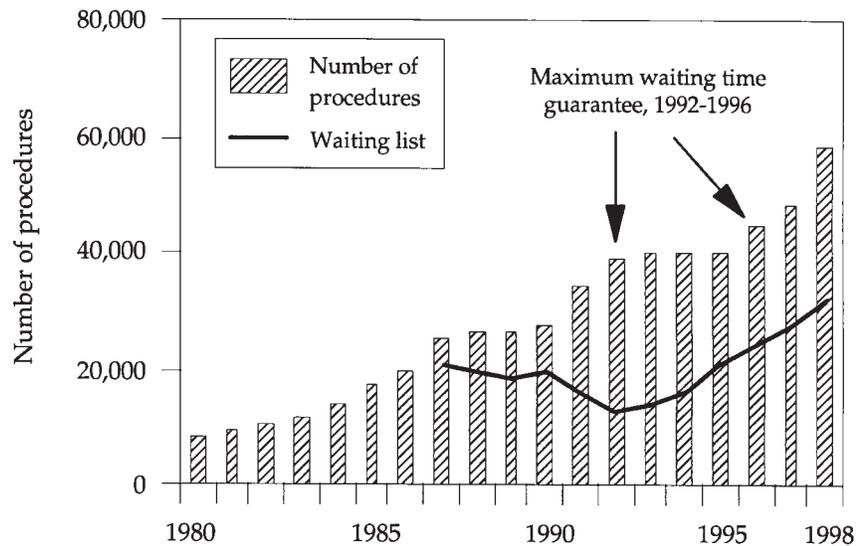
Measures to reduce waiting lists and waiting times in Sweden 1998

In April 2000, the Federation of County Councils launched a national database of waiting lists and

waiting times on the Internet (www.lf.se/vantetider). The data cover waiting times for elective secondary care. Both the waiting times for a first visit and the waiting times for treatment are included. All hospitals in Sweden will report to the database via the Internet. The Federation of County Councils continues to administer the database (see figure 2).

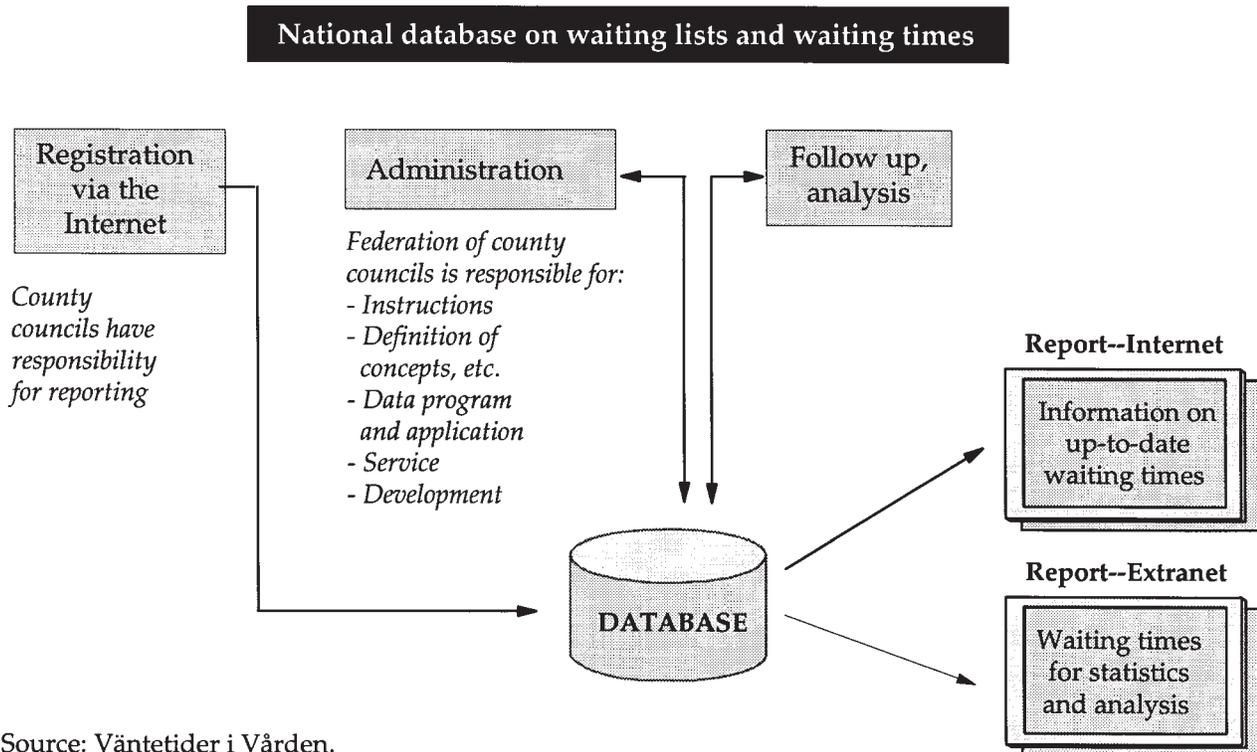
The main target group for the information is patients who want to choose between different care providers. Of course many of the patients are elderly and not that familiar with the internet. But the idea is that this information

Figure 1: Cataract Care in Sweden 1980 to 1998— Production and Waiting Lists



Source: Vantetider i Vården.

Figure 2: Organization and Administration of the Swedish Database for Waiting Lists and Waiting Times



Source: Vantetider i Vården.

will be available to everyone and therefore, should be available, for example, for patients to look at when they visit their GPs and are referred to specialists at the hospital.

The database content

The data covers waiting times and waiting lists for outpatient visits to 25 different types of clinics and specialities, 6 diagnostic procedures, and 27 different treatments in elective care. For each of the selected clinic and diagnostic procedures and treatments there is information about:

1. The *prospective waiting time* (in weeks) for a new patient on the waiting list, given that the patient is considered neither urgent nor a priority. This statistic tells patients that they do not have to wait longer than x weeks if they choose to go directly to, or are referred to a certain hospital. The clinic itself reports the prospective waiting time; it is a forecast based on knowledge about the actual situation at the clinic.
2. *The date* when the prospective waiting time was reported. The prospective waiting time is to be presented as accurately as possible. Therefore, the clinics must report changes promptly, and no prospective waiting time figure is to be older than one month.
3. *Number on the waiting lists*. All patients are included in this number, both those who have a booked date, and those who do not yet have a date. Also, all priority groups are to be included. The numbers waiting are reported three times a year: April 31, August 30, and December 31.
4. Percentage of the patients treated during the last four months that have an *actual waiting time less than 3 months*. Reporting periods: January-April, May-August, and September-December.
5. *Production* during the last four months, i.e., the number of "new patient" appointments, or the number of procedures. Reporting periods: January-April, May-August, and September-December.

Since the waiting time differs from patient to patient, and since according to the Health Care Act it should be an individual's need for care that determines his or her clinical priority, it is difficult to find a single measure on the internet database that gives individual patients a definitive idea where they are in the queue. The information about the prospective waiting time can only be a rough measure of how long the waiting time will be at different units. Therefore, it is also important to give information about the actual times that patients who were treated during the last four months have had to wait, as well as data on how many people there are on the waiting list on a certain date. It is also critical to teach patients how to interpret the data, and explain to them about patients' rights to information and choice, and where more detailed information can be found. All this is included on the web site.

A separate database on a special extranet gives managers and politicians information on waiting lists. In addition to the information available on internet, the extranet gives the following measures on actual waiting times:

1. The number on the waiting list who have waited longer than 12 months.
2. The median waiting time.
3. The waiting time for the 90th percentile by which time all but 10 percent of procedures have been completed.

Reporting periods for these figures are: January-April, May-August, and September-December.

Another measure that can help improve people's access to elective care is to implement the Council of Europe's Recommendation (No. R (99) 21) on "Criteria for the Management of Waiting Lists and Waiting Times in Health Care."

Apart from some general considerations about the function of waiting lists in health care services as well as policy goals, the recommendation deals with the issues of:

- Criteria for assessing and treating patients
- Registration of patients on a waiting list
- Criteria for admitting patients from waiting lists
- Monitoring waiting lists and waiting times
- Informing patients
- Informing staff
- Informing the public
- Management of waiting lists and waiting times
- Organizational development
- Further research into waiting times and waiting lists in Europe

At the county level, different Maximum Waiting Time Guarantees are still in force. Six of the 21 county councils have made their own decisions to have waiting time guarantees. They vary in scope but all stipulate that the patient should have the right to go to another caregiver if the waiting time exceeds the time limit that has been decided upon.

The Federation of County Councils has been supporting the county councils with methods to carry through local improvement work on accessibility and waiting times. The methods used are:

- Breakthrough series
- Idealized design of clinical office practices

Both methods have been developed at the Institute for Healthcare Improvement, Boston, USA, and more information can be gained from www.ihl.org.

Experiences from the past and initiatives to come

The debate about waiting lists in Sweden emerged from questions of efficiency, and has, over the years, become more a question of patients' rights. There have been some reflections about priorities *vis a vis* waiting lists, but these have not resulted in any explicit policies about rationing and waiting lists.

Generally, doctors have not shown a great deal of interest in the question. One reason could be that they consider themselves to be in control of the situation, and use waiting lists as an instrument for demanding resources. As long as the queues do not endanger medical quality and results, the doctors are unconvinced that all patients must be given a limited waiting time. A follow-up of the implementation of the original waiting-time guarantee policy (Hanning and Winblad-Spångberg, 2000) showed that due to economic restraints, the guarantee became a threat to established values, making physicians more resistant to the suitability of the guarantee over time.

Other experiences gained from the waiting list initiatives are:

- Waiting lists are a complicated interplay between demand and supply. More resources are not the only answer to a more efficient way of managing waiting lists.
- Too much attention is given to the supply side when there is a need for better knowledge and discussion about the indications and priorities that are applied at the clinical level.
- Concentration on a single step in the care process can create longer waits between other

steps in the process, i.e., imposing limits on the waiting time for treatment can give rise to longer waits for outpatient visits.

- Patients' influence and freedom of choice have increased, but few patients use the opportunity to change provider.
- There is a lack of common terms and rules for the management of waiting lists and waiting times in Swedish health care.

Access to health care and long waiting times are among the most discussed topics in the current health care debate. If the Swedish health care system cannot deliver better services and shorter waiting times, the citizens' trust in the system will fade, and there will be problems motivating the population to pay taxes. Therefore, in November 2000, the Swedish Riksdag (parliament) decided to develop a national action plan for health care in the years ahead. With a funding increment of MSEK 9,000 (approximately US \$900 million), and through a process involving development agreements and local action plans, the government aims to improve the quality of and access to primary care, elderly care, and psychiatry.

To further stress the importance of the county councils tackling long waiting lists, in April 2001, the state and the Federation of County Councils came to another agreement. Between 2002 and 2004, another MSEK 3,750 will be allocated to the county councils. The details of this initiative are still to be settled, but the agreement is clear that its long-term aim is to offer all patients care within three months.

Power to the patient: how the databases work

There are several levels of waiting list. There are web pages from the Swedish Federation of County Councils (www.lf.se/vantetider), other web pages from regional organizations like the Stockholm County Council (www.sll.se) and

still others from specific hospitals, such as www.stgoran.se.

What follows is a sample of the waiting times in April 2001.

This example concerns a male patient in Stockholm with a hernia. He goes to his local clinic and is referred to a specialist. He decides he wants to go to the specialist with the shortest waiting time. To find out who that specialist is, he looks at the web page of his local county council: http://www.sll.se/w_vanta/17592.cs.

He then clicks on the link for general surgery (KIRURGI, *Allmänkirurgisk mottagning*) and finds waiting times for the four categories that a patient can fall into: Klar Diagnos Oprioriterad or "Clear Diagnosis Non-Urgent," Klar Diagnos Prioriterad or "Clear Diagnosis Priority," Oklar Diagnos Oprioriterad or "Unclear Diagnosis Non-Urgent" and finally, Oklar Diagnos Prioriterad, or "Unclear Diagnosis Priority." The patient's need and right to know maximum waiting times, regardless of the category into which he or she falls, explains the use of four categories. There is also a rule in most counties that if a patient sees a GP, but the GP is unable to diagnose the illness, the patient has the right to see a specialist within one month—hence the need for four categories instead of two.

The patient in our example now tells his doctor he'd like to go to Järva Hospital since there is no wait there, regardless of whether or not the diagnosis is clear, or whether or not he is on the priority list.

This is only one example. This patient would not have received treatment so quickly if he had a number of other ailments, or if he lived in a county with longer waits. If he needed it, there is a list compiled by the Swedish Federation of County Councils where waiting times for all hospitals in all counties are displayed.

Table 1: Abbreviated List of the Waiting Times for General Surgery, Sweden

Hospital	Longest expected waiting-time, in weeks, for a non-urgent patient to see a doctor	Latest update of expected waiting time	Total number of patients waiting for a first planned visit to the doctor April 30, 2001	Percent (%) of patients that received a first planned visit to the doctor within 3 months, Jan-April, 2001	Number of planned first visits to the doctor, Jan-April, 2001
Dalens Närsjukhus, Stockholm	1	2001-06-20	Ej rapporterat	Ej rapporterat	Ej rapporterat
Järva Närsjukhus, Stockholm	1	2001-06-13	Ej rapporterat	Ej rapporterat	Ej rapporterat
Sabbatsbergs Närsjukhus, Stockholm	2	2001-06-20	Ej rapporterat	Ej rapporterat	Ej rapporterat
Täby Närsjukhus, Stockholm	2	2001-06-20	Ej rapporterat	Ej rapporterat	Ej rapporterat
Nacka Närsjukhus, Stockholm	2	2001-06-20	Ej rapporterat	Ej rapporterat	Ej rapporterat
Citykliniken, Kristianstad	2	2001-10-08	Ej rapporterat	Ej rapporterat	Ej rapporterat
Bergsslagssjukhuset, Fagersta	2	2001-06-15	159	91	Ej rapporterat
St Görans Sjukhus, Stockholm	3	2001-06-20	Ej rapporterat	Ej rapporterat	Ej rapporterat
Danderyds Sjukhus, Stockholm	3	2001-06-20	Ej rapporterat	Ej rapporterat	Ej rapporterat
Sjukhuset i Simrishamn	3	2001-09-20	25	100	Ej rapporterat
Lasarettet i Ystad	3	2001-09-18	Ej rapporterat	Ej rapporterat	Ej rapporterat
Södersjukhuset, Stockholm	4	2001-06-20	Ej rapporterat	Ej rapporterat	Ej rapporterat
Huddinge Sjukhus, Stockholm	4	2001-06-20	Ej rapporterat	Ej rapporterat	Ej rapporterat
Södertälje Sjukhus	4	2001-06-20	Ej rapporterat	Ej rapporterat	Ej rapporterat
Kungälv Sjukhus	73	2001-09-12	429	65	506
Länssjukhuset Ryhov, Jönköping	74	2001-09-26	277	Ej rapporterat	Ej rapporterat
Ludvika Lasarett	78	2001-06-18	479	50	663
Frölunda Specialistsjukhus, Göteborg	104	2001-10-11	400	Ej rapporterat	Ej rapporterat
Örnsköldsviks Sjukhus	160	2001-10-01	620	25	Ej rapporterat

Note: Ej rapporterat = Not reported.

To see a specialist in general surgery can take between 1 and 160 weeks depending on which hospital one goes to. The list for General Surgery, or *Allmän kirurgi*, is 10 pages long, and a short version looks like table 1.

The first row of table 1 shows the name of the hospital, or clinic, and where it is located. For a patient living in Örnsköldsvik, and wanting to go to Örnsköldsviks sjukhus (hospital), the second row shows an expected longest waiting time of 160 weeks for a non-urgent patient to see a specialist. The different county councils have slightly different rules, but in general, a patient faced with such a long waiting time

will have the option to see a specialist at another hospital. Since the full 10-page list includes all hospitals and clinics in Sweden, showing the one with the shortest waiting time first, one has only to look at the first hospital to see that there is only a one-week wait to see a specialist. If the patient is non-urgent, he or she can therefore ask the doctor to be remitted to that hospital. For further explanation of the other rows in the table, see "the database content" section above.

There is no law or requirement that a patient must see a GP before seeing a specialist. In reality, however, many patients want to consult their family doctor or a GP before seeing a specialist.

Table 1 shows that there was a wait from 1 to 160 weeks to see a specialist, depending upon where in the country the patient lived. On top of that, there is a waiting line to get the treatment or surgery. For hernia treatment, there was a waiting time of between 1 and 340 weeks in mid-October of 2001. The list is shown on http://sas.lf.se/appl/html/rappport/Behandling/rappport_11.htm, a list very similar to the one above. The man in our example had a maximum wait of less than a week to see the specialist, and one week to get his treatment. Even if many patients in Greater Stockholm are less fortunate than he is, the waiting times for surgery are generally less than three months.

Most counties guarantee that the patient will get treatment within three months, and the patient can, together with his doctor, decide which hospital to go to. These waits are also the longest possible waits, and can be a lot shorter if the patient's case is deemed urgent or very urgent. If such is the case, most treatments take place within a few days or weeks depending on the urgency.

Problems with the database and its future

Many fields in table 1 are labelled "Ej rapporterat," or "Not Reported." The initiative for this list came out of a desire to measure expected, and actual waiting times, and to do something about long waiting times. However, the doctor who has the task of reporting the data may not feel it is in his or her best interest to report. Some believe that waiting lists serve, in part, as a means to get more money to a specific unit. By showing that many patients are waiting for treatment, the clinic is also showing that it needs more money to perform these surgeries. The government, on the other hand, has often been elected, in part, to reduce waiting lists.

Politicians have deemed the patient's right to choice and availability more important than hos-

pitals' potential desire to show long waiting times. Since the government has not passed legislation enforcing people's right to get treatment within 3 months but instead has let the county councils agree to simply promise to provide treatment within 3 months, other methods have had to be used to ensure that hospitals report data correctly.

The waiting list project was started in 1996, and between 1996 and 1998 a limited number of clinics and hospitals took part. A few county councils in the south of Sweden were interested in compiling data, and they instructed the clinics and hospitals within their county to provide data to a national database, run by the Swedish Federation of County Councils. In the beginning, only 50 out of 350 clinics were able to provide data on actual waiting times. Without historic data, it is hard to predict future estimated waiting times. The first task was, therefore, to create systems to compile data on actual waiting times. This was done either by using computer systems, or collecting data from handwritten journals. In 1999, the project leader Marianne Hanning was visiting Denmark and found that colleagues there used a data warehouse computer system called SAS. This system was implemented in Sweden, and at the turn of the millennium the first measurement was made, and the data put into the new computer system. Since this is a national project, there is now a desire to get data from all over Sweden.

As of the fall of 2001, less than half of the units were reporting. One problem has been that many units are understaffed and/or lack proper computer systems to easily compile the data needed. To correct this, the government is spending an additional 1.25 billion crowns (about Can \$185 million) during each of the three years from 2002 to 2004 inclusive. This extra money will only be paid out to the county councils if they deliver the data required to get a comprehensive national database of estimated as well as actual waiting times. Many units and hospitals will use part of

the money to development computer systems that will enable them to collect data.

One difficulty here is that generally, the hospitals have incompatible computer systems, which means, for example, that they can't read computerized patient journals from other hospitals. This, in turn, makes it more difficult for a doctor at one hospital or clinic to fully understand what illnesses are being treated, and which treatments are being performed, at other facilities. The Swedish Federation of County Councils aims to get a compatible system in the future, but so far no software provider has been interested in the Swedish health care market, which seems to be too small to be able to bear the costs of developing a comprehensive national data collecting and data displaying tool. In the near future there are plans to include actual, and not only estimated waiting times, since what is shown now is only what the different hospitals and clinics estimate to be the longest waiting time.

Since this is a project in progress and much more has to be done before it works perfectly, it is of interest to take a look at the county council that has the best system today. The county of Östergötland explains how they work on the web site: http://www.lio.se/Utm/enkel_sammatypsn.ASP?CategoryId=5000. I have translated the following from the site:

About 85 percent of all patients who visit the hospitals are emergency patients, or they have an appointment. About 15 percent of the patients have to wait to see a doctor. A small percentage must wait longer than 3 months to receive hospital treatment.

The county council of Östergötland regularly analyzes the waiting times at the hospitals. The follow up is based on what the clinics register in the patient-administrative systems (ADAPT and ATIS). The results are presented in reports for every four-month period.

The follow up is both for the time waited from seeing a GP to sending a referral to a specialist, to the first contact with a specialist, as well as the waiting time from the decision to treat to actual treatment. This is done for roughly 30 illnesses.

We measure three different waiting times:

Faktiska väntetider or "actual waiting times" shows how long patients waited between visiting the hospital and receiving treatment.

Aktuella väntetider or "current waiting times" shows how many people are actually on the waiting list, and how long they can expect to wait before receiving treatment.

Förväntade väntetider or "expected waiting times" shows the estimated longest time a new patient can expect to wait to see a specialist or receive treatment for about 30 different illnesses. This count is based on the longest expected waiting time for those with the lowest priority, which means that the great majority of patients will be taken care of much quicker. The expected waiting times will be updated monthly and shown on the Internet together with data from all other hospitals in Sweden.

The Emergency Room at St. George's—On-Line

The best example of a hospital that really seems to put the patient first is St. George's. It is the first hospital in Sweden to show estimated waiting times for access to the emergency room, updated in real time at <http://tid.stgoran.nu/scripts/wsisa.dll/WService=skreg/xinfo?sida=akutvante>. I have translated key data from this site (see table 2).

To my mind, the St. George's site is one of the clearest indications of a change in attitude toward patients. In the 1980s, the patient was not the focus. Politicians and doctors seldom talked about patients, but rather talked about procedures or budgets. After protests and dissatisfaction with long waiting lines and lack of information and choice, patient-centred changes emerged in the 1990s. When a private company was awarded the contract to run St. George's in 1999, the focus had already shifted towards the patient. The ability to see estimated waiting times for the emergency room is a huge step forward from the "old" days.

Table 2: Waiting Times for Access to St. George's Emergency Room, October, 2001

	Orthopaedic ER	Surgery ER	Medicine ER
Number of patients waiting	6	11	10
Waiting time to see a nurse (minutes)*	8	17	9
Waiting time to see a doctor (minutes)*	43	76	80

Updated October 12, 2001, at 10:04 p.m.

*Estimate based on experience with time taken to treat different conditions. A priority is also made depending upon how acute the injury or illness is. When patients whose priority urgent arrive, the waiting times can change rapidly.

Source: St. Göran's Artroclinic AB.

Back then, a hard chair and hours of endless waiting with no information whatsoever regarding how long one had to wait, was the result of having the misfortune to become ill.

Waiting Lists in Greater Stockholm Compared to Greater Vancouver

Trying to compare waiting lists in two countries, or even two cities, is problematic. A number of parameters differ. The way patients are placed on waiting lists will be different in different cities—sometimes different between two clinics in the same city. There is also the question of demographics. A society with an aging population will have more people in need of treatment compared to a society with younger inhabitants. For the past 15 years, Sweden has had a larger proportion of elderly than has Canada. The elderly comprise about 17.5 percent of Sweden's population compared to about 11 percent in Canada, according to the OECD. This means that Sweden has

about 50 percent more people over the age of 65 as a proportion of its population than does Canada, and thus the pressure on the Swedish health care system is greater than the current pressure on the Canadian health care system.

Keeping this important difference in mind, table 3 compares waiting times for a number of procedures where comparable figures are available. The comparison is between Greater Stockholm and Greater Vancouver, two fairly large cities that are similar in size. The chart shows the longest possible waits for non-urgent patients to see a specialist and to receive treatment.

Table 3: Longest Possible Waiting Times in Greater Vancouver and Greater Stockholm for Non-urgent Patients to See a Specialist and to Receive Treatment, Selected Procedures

	Greater Vancouver (waits in weeks)		Greater Stockholm (waits in weeks)	
	Spe- cialist	Treat- ment	Spe- cialist	Treat- ment
Anthroplasty (Stockholm = HIP, KNEE)	60	60	55	62
Cardiology–Coro- nary artery bypass	16		17	
Gynaecology– Hysterectomy	24	52	9	21
Neurology	24		26	
Ophthalmology– Cataract	26	52	31	39
Plastic Surgery– Breast Reduction	40	52	17	96
Tonsillectomy	8	52	17	209

Source: Swedish Federation of County Councils, www.lf.se and The Fraser Institute, www.fraserinstitute.ca.

Since choice and accessibility are the two guides in today's health care in Stockholm, a new patient visiting a GP will be shown all waiting times for all clinics and, together with the GP, will then choose which one is the best for him or her. Table 4 lists the waiting times for selected treatments for patients in either city choosing the specialist and the treatment with the shortest waiting times.

As table 4 shows, the waits in both cities are fairly similar. The real difference, however, is that Stockholm's care guarantee ensures that practically nobody in that city has to wait longer than three months. The Stockholm patient will be offered the option of seeing a specialist or receiving treatment at another hospital if the wait is longer than 3 months at his or her original choice of hospital. The Stockholm patient can also choose which clinic to go to, and would likely choose the one where he or she would have to wait the least

Table 4: Shortest Waiting Times Between GP and Specialist, and Between Specialist and Treatment in Greater Vancouver and Greater Stockholm, 2001

	Greater Vancouver (wait in weeks)		Greater Stockholm (wait in weeks)	
	Spe- cialist	Treat- ment	Spe- cialist	Treat- ment
Anthroplasty (Stockholm = HIP, KNEE)	4	6	1	4
Cardiology	2		1	
Gynaecology– Hysterectomy	1	6	1	4
Neurology	4		3	
Ophthalmol- ogy–Cataract	2	8	1	14
Plastic Surgery– Breast Reduction	3	6	6	7
Tonsillectomy	1	6	1	3

Source: Swedish Federation of County Councils, www.lf.se and The Fraser Institute, www.fraserinstitute.ca.

amount of time. In Vancouver, patients can get information regarding waiting times by contacting individual doctors, but this is a more cumbersome procedure.

I grew up in Sweden with long waiting lines and public dissatisfaction with the situation. For me, the current debate on long waiting times in Greater Vancouver reminds me of the public debate in Greater Stockholm in the 1980s. Back then, it was common to wait a year for a hip replacement or eye surgery. Unfortunately, Canada has no maximum waiting time guarantee, so many people in this country face a situation similar to the one in Greater Stockholm 15 years ago. To make matters worse, the percentage of people over the age of 65 in Canada will reach the Swedish proportion within 15 years. This means that there will be about 50 percent more people over the age of 65 than there are now, and with this comes an increased demand for health care.

Different Ways of Measuring the Number of People Who Need Treatment

One of the longest waiting lists in Sweden in the 1980s and early 1990s was for cataract surgery. Table 5 shows the number of cataract procedures per year in Sweden, the number of people waiting in line, and the average waiting time:

As table 5 shows, the number of procedures performed per year increased, thanks to more efficient methods and equipment. At the same time, the number of people waiting in line also increased. If one only looks at waiting lines, one would conclude that the problem with long waiting lines escalated. Is this necessarily the case?

The most common way of measuring the availability of different treatments is to look at waiting times. Even though waiting lists are an important indicator of availability, they are just one indicator, and taken alone can be misleading. Developments in the health care sector, including new treatment methods, surgery and medicines, have enabled more patients to be treated. This means that a larger proportion of the population can be treated, for example, for cataracts. In 1990, 27,500 patients had cataract surgery undertaken with improved methods. That number rose to 60,000 in 1999. At the end of 1991, there were 20,000 pa-

tients waiting for an operation; at the end of 1997, 25,000 were waiting (SOU, 2001, p. 79). Clearly, society as a whole is better off when more people suffering from impaired vision can be treated. Therefore, it would be valuable to find a way of measuring the number of people with a specific illness that are actually offered treatment, as well as measuring how quickly they were treated.

Table 5: Cataract Procedures in Sweden, 1987-1996

Year	Number of procedures performed per year	Number of patients waiting for procedure	Average wait (months)
1987	24,800	21,000	10.1
1988	26,500	19,000	8.6
1989	26,800	18,200	8.1
1990	27,500	19,500	8.5
1991	34,000	16,153	5.7
1992	39,400	12,981	4.0
1993	39,900	13,300	4.0
1994	40,200	15,500	4.6
1995	40,000	20,100	6.0
1996	44,700	24,000	6.4

Source: Marianne Hanning, Federation of County Councils, Sweden.

The Monetary and Humanitarian Costs of Waiting in Line

There are many ways of calculating how much waiting in line costs both society and the individual. Since many people in line are seniors who don't work, calculating the cost may seem difficult. If an employee who makes \$100,000 a year is unable to work for a year while waiting in line, it can be argued that

the loss to society is the loss of output from that employee. One can also argue that tax revenue from the \$100,000 will also be lost, and that there is the added cost of social assistance, which is borne by society. For a senior citizen unable to take care of herself because of her illness, it can be argued that the cost of her care-

giver can be used to calculate the cost for her waiting in line.

Even if society accepts the cost of lost production, and accepts people suffering while waiting, they may be less understanding if people die while waiting in line. Since everyone gets sick from time to time, having to wait in line is something that can happen to all of us, and thus people are generally upset when they read about patients suffering and having to wait a long time for treatment.

In Gothenburg, in Sweden's southwest, 77 people died while waiting for coronary surgery between 1995 and 1999. Their deaths could be considered the ultimate cost of waiting in line—people pay-

ing with their lives. A study from Sahlgrenska Hospital in Gothenburg shows that 31 of the 77 patients in line would most likely have survived until surgery if the recommended maximum waiting times had not been exceeded (Dagens Nyheter, Nov 29, 2001). The guidelines stipulate that patients considered in urgent need of treatment should have surgery within 14 days, and patients who are classified as semi-urgent should have surgery within three months. The actual waiting times for the Gothenburg patients ranged from 29 to 104 days. Since many counties are unable to guarantee treatment within a reasonable time frame, the question has to be, "are there no alternatives?" No one wants to die waiting in line.

Private Insurance: Waiting Your Turn—Or Not

Today there are some 100,000 Swedes who don't wait their turn for health care. They have private insurance, paid for by their companies, which guarantees immediate treatment.

According to the rules, one can only get this treatment in the private health care sector. In reality, the county councils buy health care from private clinics and hospitals and the private ones remit the patient to the county council hospital or clinic if they have no resources or if the procedure is too complicated. This means that some people with private health care insurance who are remitted to a public hospital may very well jump the queue, but private caregivers also treat patients in the public waiting line, thus reducing the waits for the rest of the patients in the line. According to *Pockettidningen R 1/2000*, public debate has focused more on the possible problem of queue jumping, and the politicians and the Swedish public are doing what they can to prevent a two-tier system. In reality, a two-tier system has existed in this form for over 15 years, and more and more people want to be part of it every year.

It is also possible to go to a private caregiver and pay 30,000 crowns (Can \$4,500) for immediate groin hernia surgery, or 40,000 crowns (Can \$6,000) for a facelift. This component of the health care market will never be really large simply because too few people can afford it. What some see as a threat to the public health care system comes instead from the four major insurance companies. (If the private sector were seen as helping the public sector alleviate some of the problems with long waiting lines, it would be viewed as a necessary complement to public health care, not a threat at all.) These companies offer insurance for key personnel, who are often well educated, well paid middle-aged people. These people are guaranteed quick and efficient treatment whenever they need it. If they get ill and it's acute, they will be treated within the public system immediately, but if they need elective surgery, they have the option to jump the queue, or get treatment from private caregivers who are unavailable to those in the public waiting line. Skandia, who was the first to offer this type of insurance, has about half of the market. It uses five private hospitals as well as

a number of clinics throughout Sweden. If the required treatment isn't available in Scandinavia, the patient can be sent to the United States. This insurance is called "Lifeline Preferred Health Care," and costs about 15,000 crowns (Can \$2,300) per year for a 50-year old, and about 24,000 crowns (Can \$3,600) per year for a 60-year old. Skandia only insures people up to age 67. The Skandia web site (www.skandia.se) gives additional information.

Försäkringsrådgivarna offers private insurance on-line, both for individuals and for companies who wish to insure their employees. Försäkringsrådgivarna is not an insurance company, but a broker that finds the best solution on the market (www.frab.se). The web site http://www.frab.se/files/on_line.html gives a table of costs for private insurance, and an example of when it can be useful to have such insurance. It relates the story of a woman who has hurt her foot while walking in the woods. Her doctor tells her she has to wait two months for treatment, and instead she uses her private insurance and sees a doctor and receives treatment within 8 days. She pays a deductible of 500 crowns (roughly Can \$70), which covers the surgery as well as travel to the hospital. As table 6 shows, the annual premium depends on one's age.

The cost for employees in a group insurance plan (3 to 50 people) is 1,200 crowns (about Can \$175), but as the figures in table 6 show, individuals can get the insurance for roughly the same amount while they are between ages 18 and 49.

Table 6: Premiums for Individuals

Insurance will pay up to 379,000 crowns for 2002		
Age	Insured	Co-insured
18-49 years	1,500 crowns/year	1,200 crowns/year
50-64 years	2,400 crowns/year	1,200 crowns/year
65-69 years	3,900 crowns/year	3,900 crowns/year
70-74 years	4,800 crowns/year	4,800 crowns/year
75-79 years	5,900 crowns/year	5,900 crowns/year

Skandia, the largest provider of private health care insurance, has a similar program. With it, people can contact a nurse 24 hours a day, seven days a week. The nurse guides the patient to the right level of care, and the insurance covers all costs for surgery, aftercare, travel to and from the hospital, and so on. There is no deductible or upper limit for how much it covers. The prices are roughly the same as the ones in table 6. Lars Holmqvist at Skandia explained to me in a personal e-mail that the company has some 42,000 clients, and of those, about 90 percent are companies buying the insurance for their employees. The cost is not deductible for the companies, and it is not regarded a taxable benefit for the employee.

Holmqvist has seen a rapid increase in the number of insured since 1998, and believes there will continue to be a strong increase in demand in the years to come. He explains that the insurance covers all illnesses, but that people with pre-existing conditions, such as HIV, for example, will not be able to get the insurance. If a person contracts AIDS after being insured, the insurance will, of course, be valid. I asked him whether Skandia's insurance results in people jumping the queue. He responded that his clients only use resources not used by the public health care system, and that the patients are very pleased that they don't have to wait in line to get the procedure done. In Stockholm, Skandia uses Sophiahemmet, the oldest and largest private hospital in Sweden. The hospital accommodates not only private patients, but also sells capacity to the county council, thus alleviating the waits at other, publicly-owned hospitals, and so reducing waiting lines for the general public (see www.sophiahemmet.se).

Since this trend towards private solutions is something that, officially, Swedish society wants to fight, there is one obvious way to do it. Get rid of waiting lines. If the public system cannot do so, there is a great risk that when a large enough

group has private insurance, the public system will collapse. Officially, no privately-insured person jumps the public waiting line, but in practice, the private and public caregivers cooperate closely. The same doctors circulate between both

types of hospital—the private ones and those run by the county councils.

What the Future May Hold

If half the population jumps the queue, there is a great chance that people will stop paying taxes and the public system will collapse. This is what the government is afraid of, and the project to reduce waiting lists and increase accessibility and choice must be seen as an attempt to not only offer patients (voters) better service, but also to ensure that taxpayers continue to pay taxes for public health care.

There is another way to increase spending in real terms without increasing spending as a percentage of GDP. With a high GDP growth rate, more money will be available for health care. A report from the Swedish Federation of County Councils (Landstingsförbundet, 1998) predicts scenarios for the county councils from 1999-2010. If there is a GDP growth of 2.3 percent annually, and an unchanged percentage of GDP is allocated to the counties and communities for health care excluding medicines, the real resources for health care would increase by one percent per year.

If there is no GDP growth, other measures have to be taken, probably involving a greater reliance on private health care spending. The greatest opportunity to increase private health spending is by increasing the use of insurance. A likely development is that the public health care system will take care of basic needs, while starting to restrict care for those with non-urgent needs, and for those who want “luxury care.” The latter 2 groups of patients will instead be required to satisfy their needs through the private sector (Sjukvården i Sverige 1998).

The discussion regarding waiting times has likely been a significant contributor to the already rapid increase in the number of private health insurance policies in the 1990s. In 1990, 23,000 people had private health insurance. That number had increased to 115,000 by 2000 (SOU 2001:79). This increase indicates that this type of insurance provides health care availability, by giving the insured quick and unrestricted treatment.

Conclusions

In the 1980s, Swedes suffered from long queues for health care at a time when an aging population threatened to burden the system even more in the future. If nothing had been done, the waiting lines would have been even longer today than they were then.

The waiting times in Greater Stockholm and Greater Vancouver are fairly similar today for a number of procedures for the clinics and hospitals with the shortest waits. One has to keep in mind though, that the Swedish population is older, and requires more care. Thus, logically, the

Swedish waiting lines should be longer than Canadian ones. That they are not indicates that the Swedish system is the more efficient of the two. Canada will have as many elderly as a percentage of its population in 2015 as Sweden has today. Therefore, pressure will mount on the Canadian system, and longer waiting lines will be the result if nothing is done soon to increase efficiency in the Canadian health care system. The Swedish reforms started 15 years ago, and are still an on-going process where new ideas and reforms are being tried in various counties.

Canada has some advantages over Sweden when it comes to implementing new reforms and ideas to make the health care system more efficient. First, it can learn plenty of lessons from systems like the Swedish one, about what can be done and what pitfalls to avoid. Second, when the Swedish reforms began in 1984/85, there was no internet or intranet. Information is key—not just information about where the waiting times are the shortest, but information about best practices for doctors. Today, much of this information is readily available on the internet, which should enable Canadian administrators to gather data more efficiently and disseminate it quicker. By developing an efficient information system, reforms and ideas can be implemented faster, and clinics can give better service to patients.

A database listing the maximum waiting times at all clinics, which patients can go through with their GPs, enables patients to choose doctors with short waiting times. In Vancouver, patients now have to call around themselves for that information. It is also more difficult to find information

about estimated waiting times in Vancouver. A database can also increase efficiency and reduce waiting lists by providing details about the different procedures used in different clinics; clinics with long waiting times can learn about alternative, more efficient ways to perform certain tasks. A national body such as the Federation of County Councils can be helpful in collecting the data and informing clinics about best practices.

The most important step Sweden took towards shortening its waiting lists was to implement the maximum waiting time guarantee in 1992. The guarantee stipulated that a patient had the right to receive treatment within three months from seeing a specialist and being diagnosed. It also gave the patient the right to see a specialist within three months. A comparison of the clinics and hospitals with the longest waiting lines in Greater Stockholm and Greater Vancouver today, shows that the times are actually fairly similar. The great difference is that the patient in Stockholm who has been waiting in line for three months will be given the opportunity of seeing a specialist or receiving treatment immediately, either at that clinic, or at another clinic or hospital. This way, most patients in Stockholm never have to wait longer than six months from seeing a GP to receiving treatment, unless they choose to do so, whereas in some cases, the Vancouver patient has to wait two years to receive treatment.

The maximum waiting time guarantee was implemented because of the public dissatisfaction with the old system. It is time for Canada to initiate a public debate and demand a maximum waiting time guarantee similar to the one in Stockholm.

References

- Council of Europe. *Recommendation on Criteria for the Management of Waiting Lists and Waiting Times in Healthcare* (No.R(99)21).
- Dagens Nyheter (2001). "77 avled i operationskö" (November 29).
- Hanning, Marianne, and Winblad-Spångberg, 2000
- Hanning, Marianne, interview in September, 2001
- Holmqvist, Lars, personal e-mail to the author.
- Landstingsförbundet (1998). *Landstingens ekonomi* (May).
- Pockettidningen (R 1/2000). *Sjukvårdens gräddfiler* *Förtur i kön*
- Sjukvården i Sverige (1998). *Socialstyrelsen*, pp. 34-35.
- SOU2001:79. *Välfärdspolitikens förutsättningar och utmaningar*.

Other Internet References

- http://sas.lf.se/appl/html/rapport/Behandling/rapport_11.htm
- http://www.lio.se/Utm/enkel_sammatypsn.ASP?CategoryId=5000
- <http://stgoran.nu/scripts/wsisa.d11/WService=skreg/xinfo?sida=akutvante>
- www.frab.se
- www.frab.se/files/on_line.html
- www.ih.se
- www.lf.se/vantetider
- www.skandia.se
- www.skandia.se/lifeline/privatvard
- www.sll.se
- www.sll.se/w_vanta/17592.cs
- www.sophiahemmet.se
- www.oecd.org

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