Taming of the Queue III
Ottawa, March 30 - 31, 2006

Taming the Queue – What can we learn from European experiences?

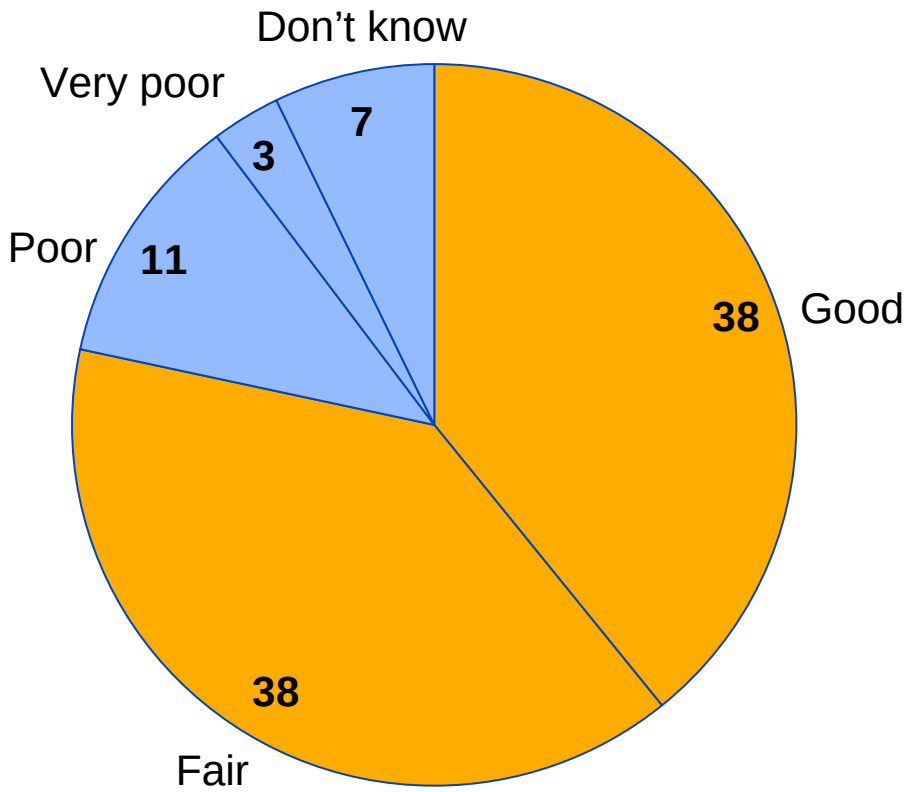
Marit P. Vaagen
McKinsey & Company

Agenda

- **Brief overview of European health care systems and wait time challenges**
- **7 ideas for how to Tame the Queue and lessons learned**
- **Key takeaways**

Europeans attitudes towards their health care systems are mostly positive

How good would you say your country's healthcare system is at meeting the individual needs of the patients it treats?



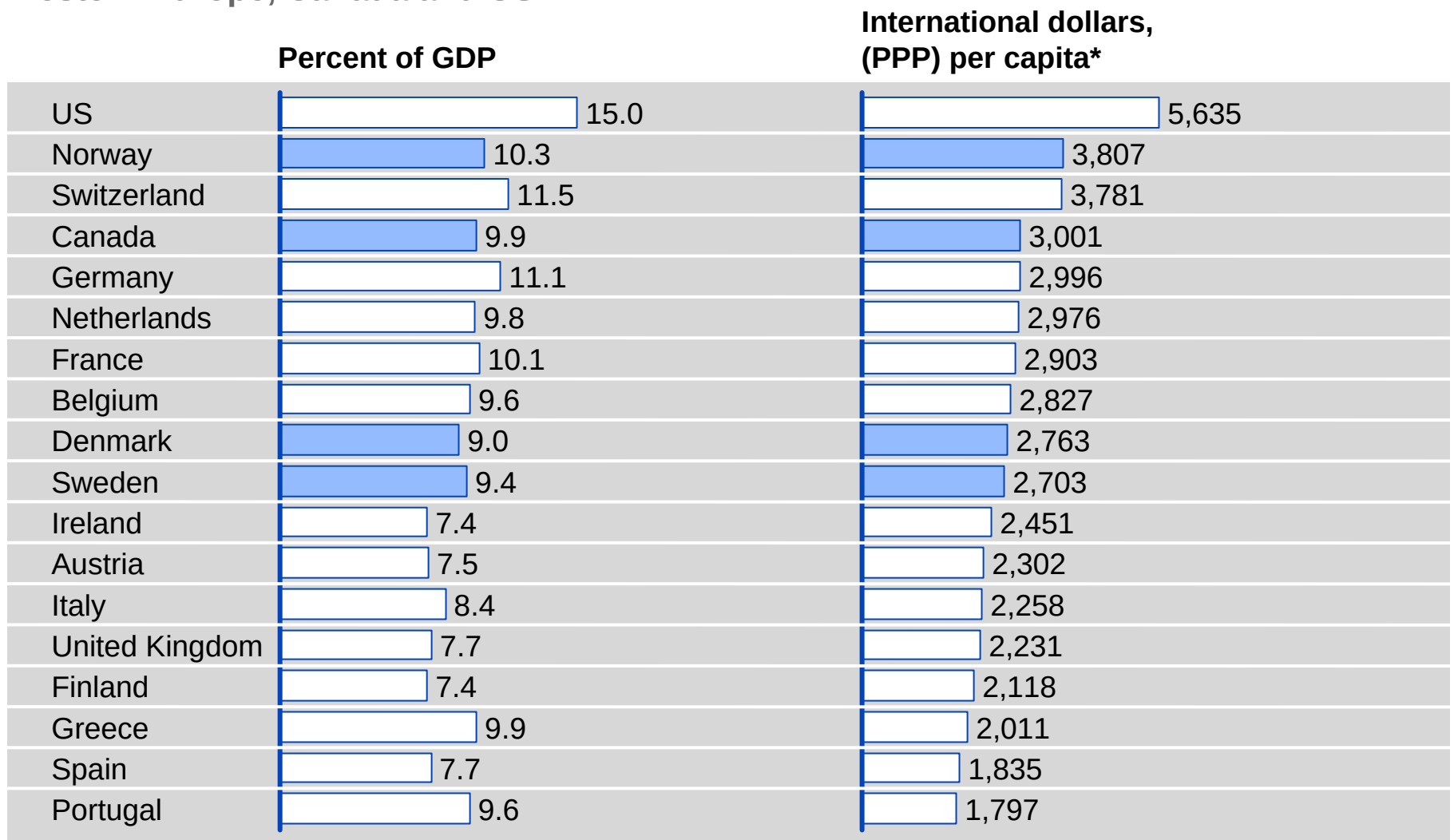
Benefits coverage in Europe is generous

	Free choice of physician	Free choice of hospital	Co-payment at specialists	Co-payment in hospital	Dental care	Dentures in range of benefits	Sickness pay/ sickness benefit
Germany	✓	✓		✓	Com-prehensive	✓	> 50%
United Kingdom					Limited	✓	Lump sum
Sweden	✓		✓	✓	Restricted	✓	> 50%
France		✓	✓	✓	Com-prehensive	✓	> 50%
Austria	✓	✓		✓	Com-prehensive	✓	< 50%
Netherlands		✓			Limited		> 50%
Denmark			✓		Com-prehensive		< 50%
Switzerland			✓		Limited		< 50%
Norway	✓	✓	✓	✓	Children: com-prehensive		> 50%

Source: Observatory Reports, WHO

Money spent on healthcare

Western Europe, Canada and US

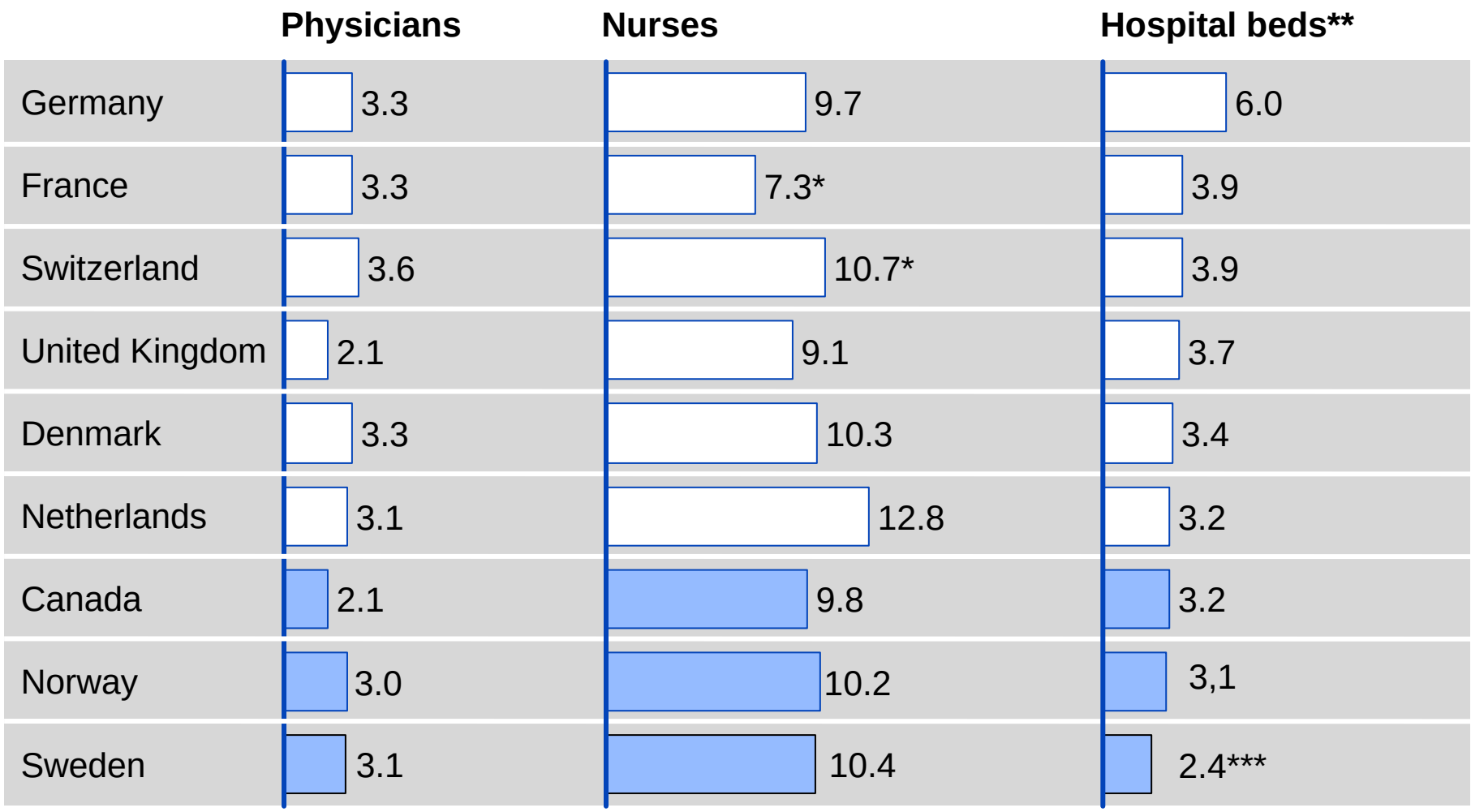


* Adjusted for purchasing power parity

Source: OECD Health Data 2005

Supply of healthcare personnel and hospital beds

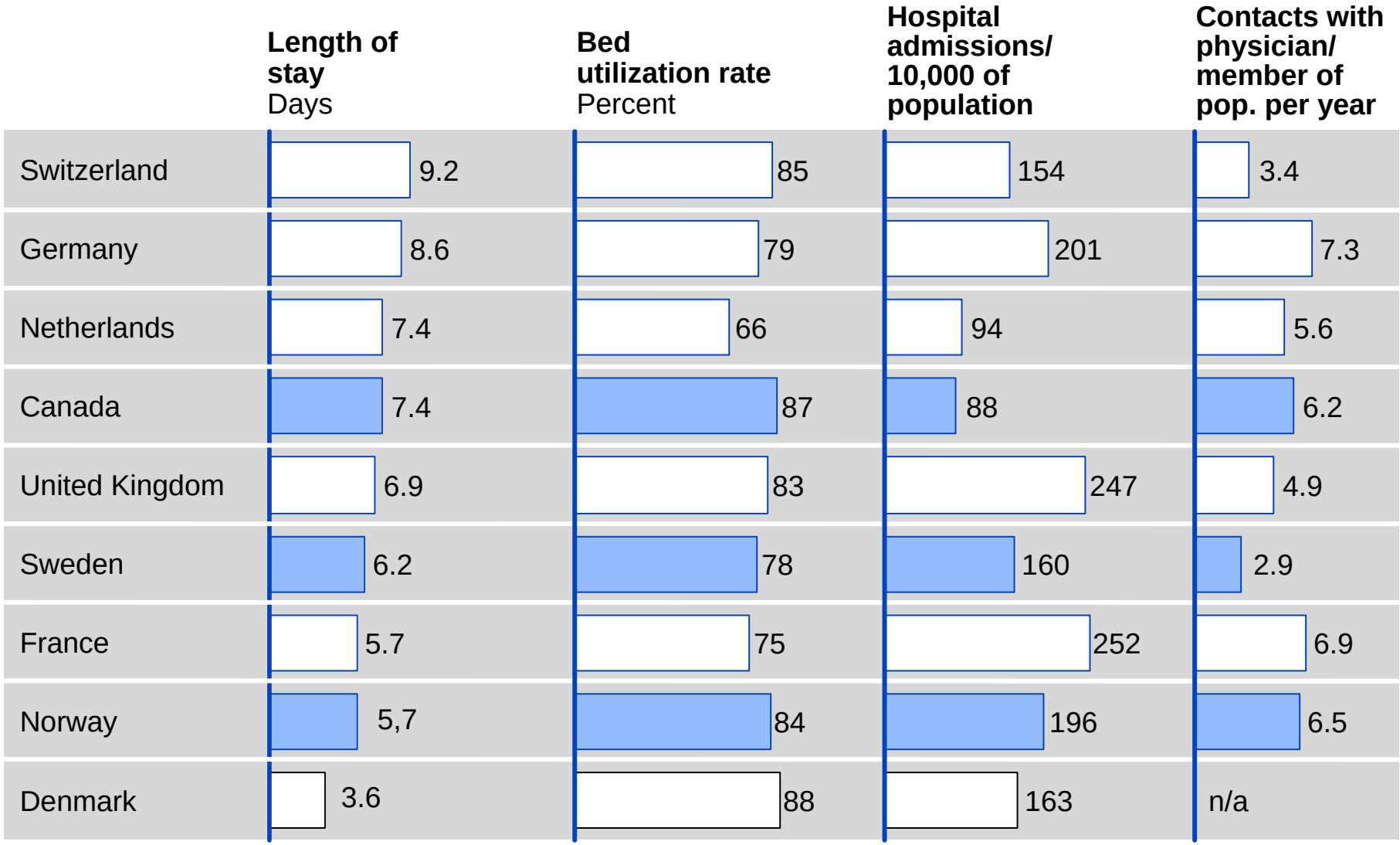
Number/1,000 of population



* 2000 ** 2002 *** 2001; all other numbers 2003

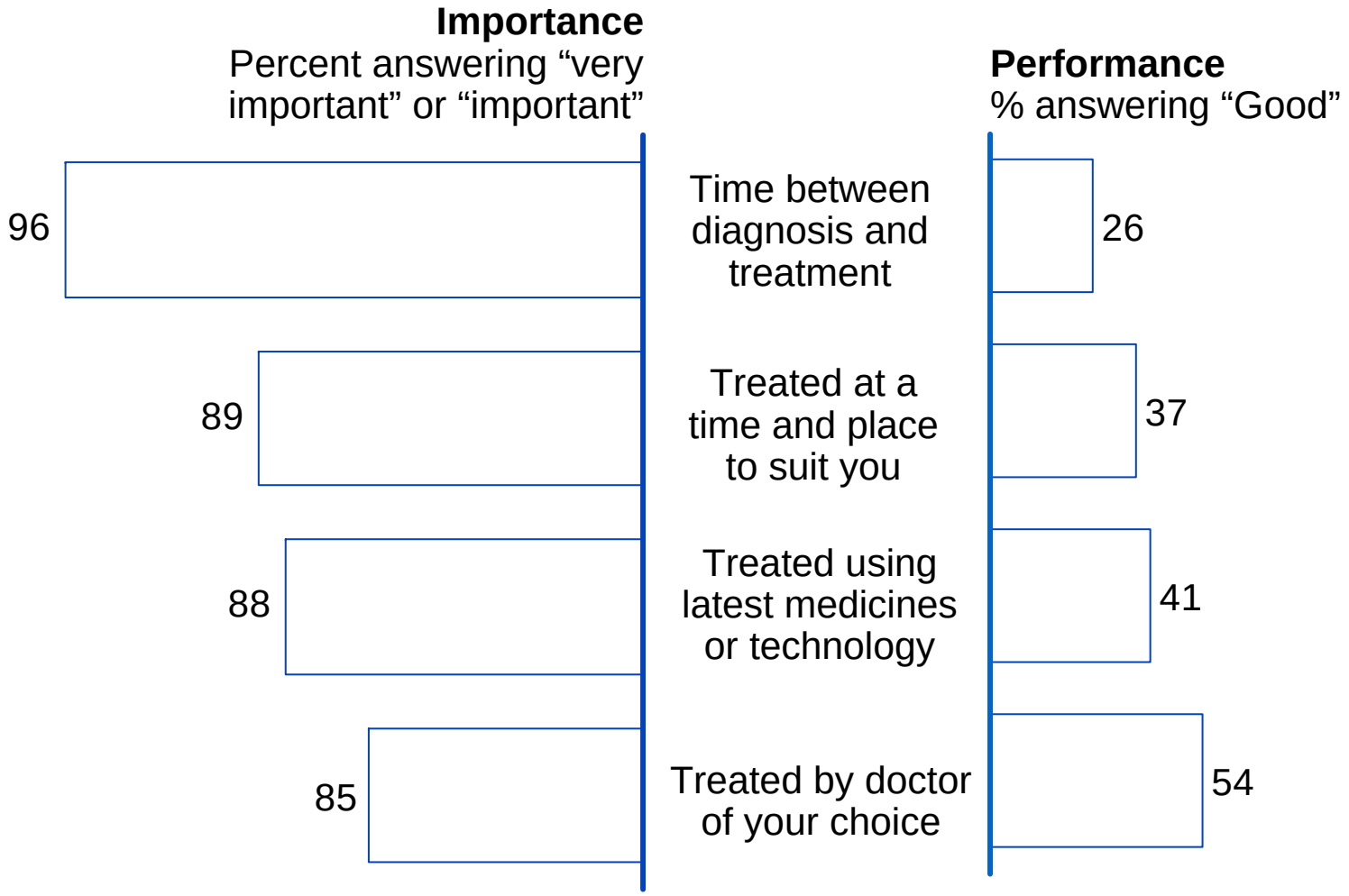
Source: Observatory Reports, WHO, OECD 2004

System effectiveness indicators



Source: Observatory Reports, WHO, OECD 2004

Europeans view wait time as the most important feature of their healthcare services

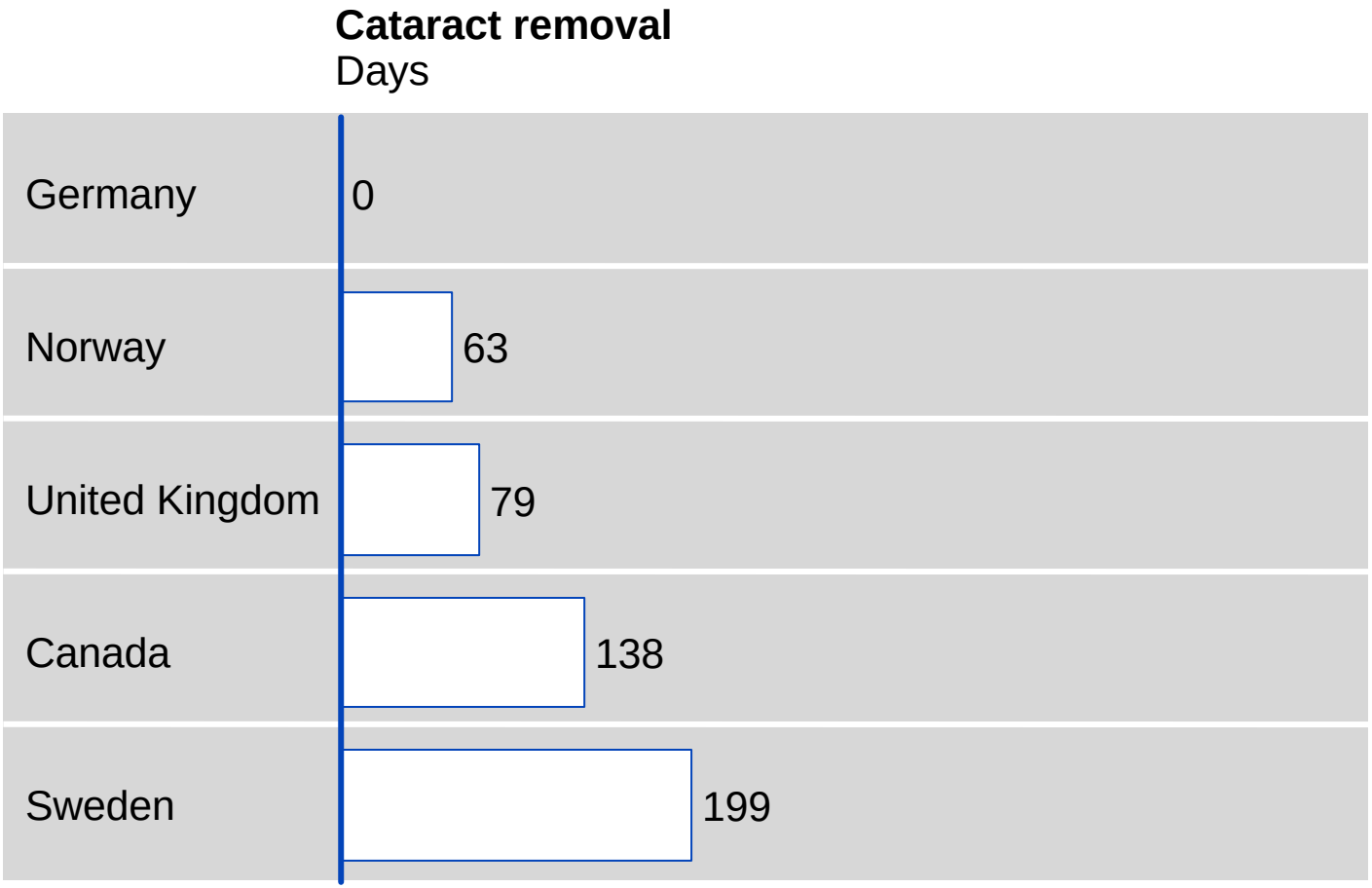


Europe has both tax based and insurance based healthcare systems; Only tax based systems are facing queuing problems

Tax based systems	Insurance systems
• Tax-financed free health care for all nationals/residents • Enrolment automatic • Global budget	• Income-related insurance premiums • Compulsory insurance • Negotiated fees for service
Costs typically controlled by queues - rationing of services	**Costs managed by raising insurance premiums**
UK, Scandinavia, Italy, Spain, Portugal	**Germany, France, Benelux, Switzerland, Austria**

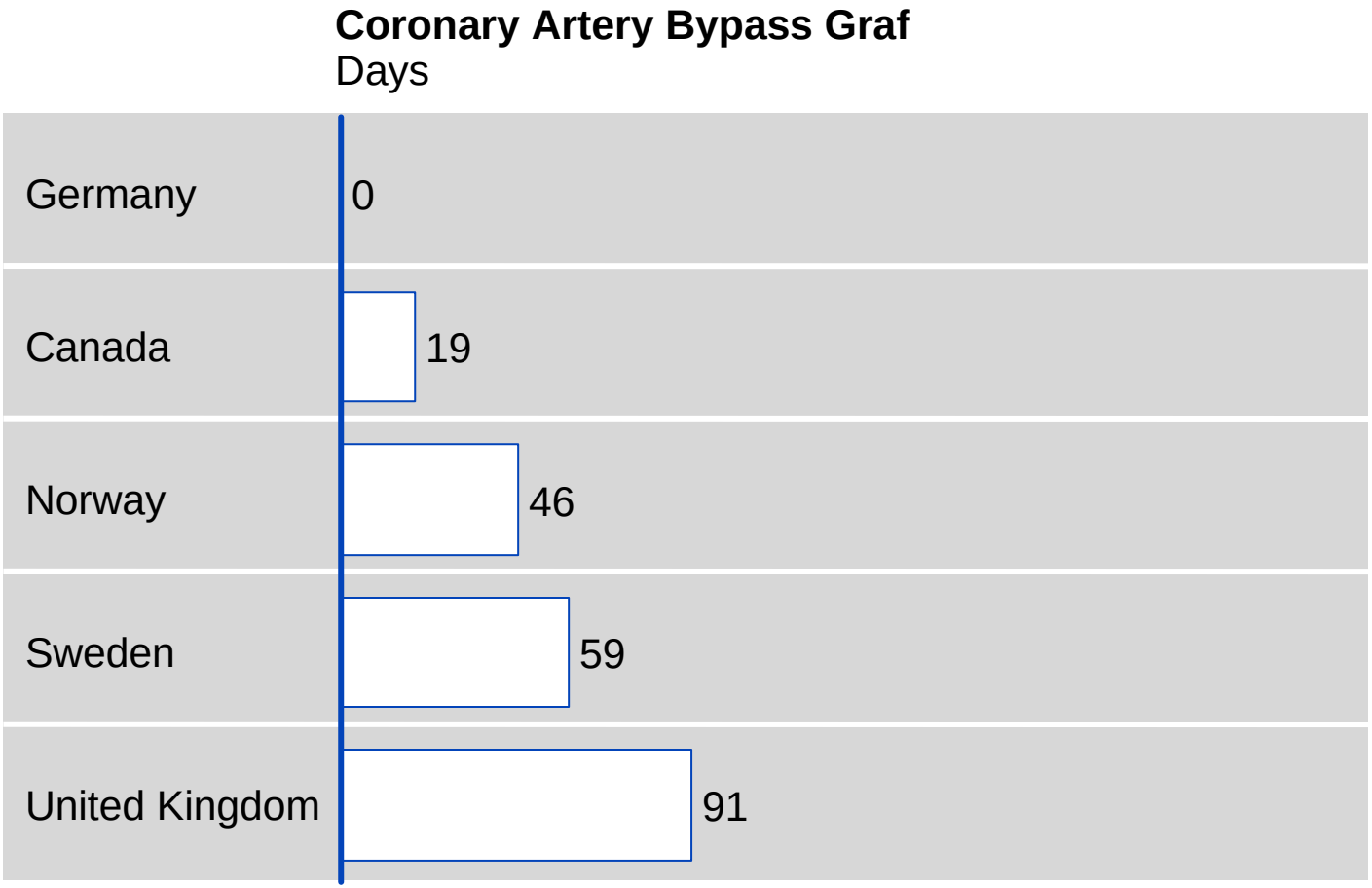
Source: McKinsey analysis

Waiting times (1/3)



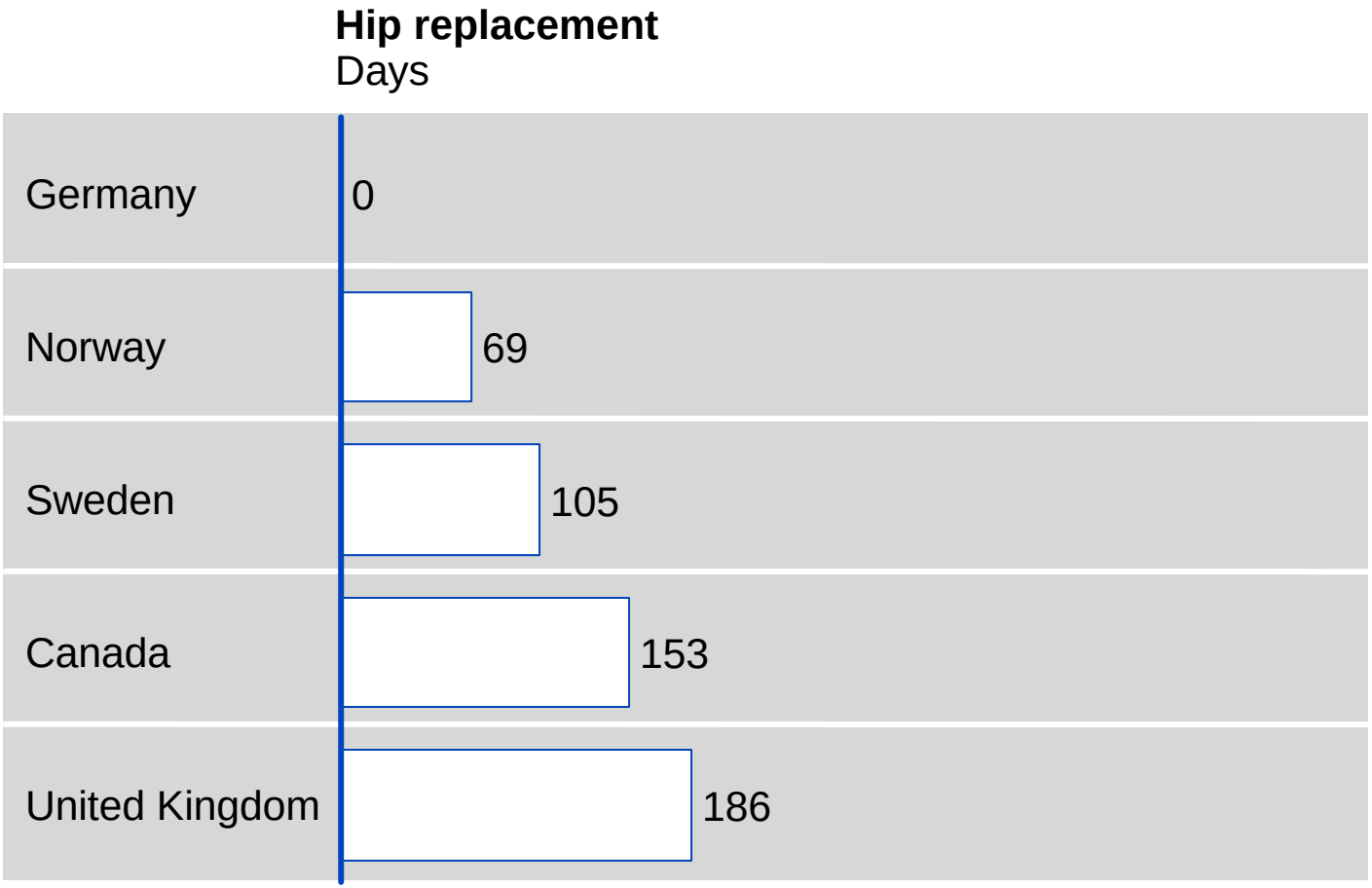
Source: HOPE 2003, Government of Ontario, Hospital Episode Statistics, Department of Health, OECD 2003

Waiting times (2/3)



Source: HOPE, WHO 2003, Government of Ontario, Hospital Episode Statistics, Department of Health, OECD 2003

Waiting times (3/3)



Source: HOPE, WHO 2003, Government of Ontario, Hospital Episode Statistics, Department of Health, OECD 2003

Why do we have queues?

- In a system where healthcare services are free, demand will always be larger than supply – queues is a way of rationing demand (bridging the gap between supply and demand)
- Financing system does not give right incentives
  - Does not punish providers who have queues
  - Does not give rewards to those who eliminate queues
- Queues persist because there is not enough innovation and sharing of best practices between providers
- Patients are (usually) not allowed to choose provider freely, therefore regional imbalances between supply and demand can exist (even if the system as a whole has sufficient capacity)
- Queues can be a “quality indicator”– “we are good providers – our services are so much in demand, we have waiting lines”
- Patients’ demands are not sufficiently heard or not taken seriously
- Queues is a way of ensuring politicians will grant larger budgets next year

Agenda

Brief overview of European health care systems and wait time challenges

7 ideas for how to Tame the Queue and lessons learned

Key takeaways

7 ideas to reduce waiting time

	Explanation	Degree of success
1. Mandate patients rights to treatment by law	• Set maximum waiting times by law • Tried in Norway – introduced by patient rights' act of 1999, effective from 2001 • Introduced in Sweden 2005	• Limited effect in Norway – Law was continuously broken: undermined the public's trust in the system and in politicians – Lead to demands for increased spending – Leads to "tactical waiting list behavior“ • Limited effect in Sweden
2. Increase spending (within own country)	• Use more money/increase capacity (increase funding)	• Limited: not an answer to the challenge – Overcapacity builds – Unused capacity remains – Fuels inflation (was a problem in Norway historically)
3. Buy services abroad	• Norwegian parliament decided in autumn 2000 to award an additional NOK 1 billion (CAD ~ 200 million) for treatment abroad (Germany, UK, Benelux, etc.)	• Limited – Norwegian doctors/nurses often oppose buying services abroad (when it is possible to provide them in Norway), thus making execution difficult – Fixed capacity will not be optimally utilized because money to cover variable costs (treatments) is being spent abroad

Source: McKinsey Payor Provider Practice

Sweden's wait time guarantee

0 – 7 – 90 – 90

0	7	90	90
Guaranteed access to your local primary care center same day	Access to see a doctor within 7 days	Maximum 90 days to see a specialist	Treatment started maximum 90 days from seeing a specialist

Sweden's wait time guarantee – Effects so far

- **Introduced November 1, 2005**
- **Has reduced wait times, at least in the official statistics**

"We have cleaned up our numbers – Some of the queues just vanished in the air"
- Regional manager

"It had an impact for us; our son finally received treatment"
- Mother of autistic child

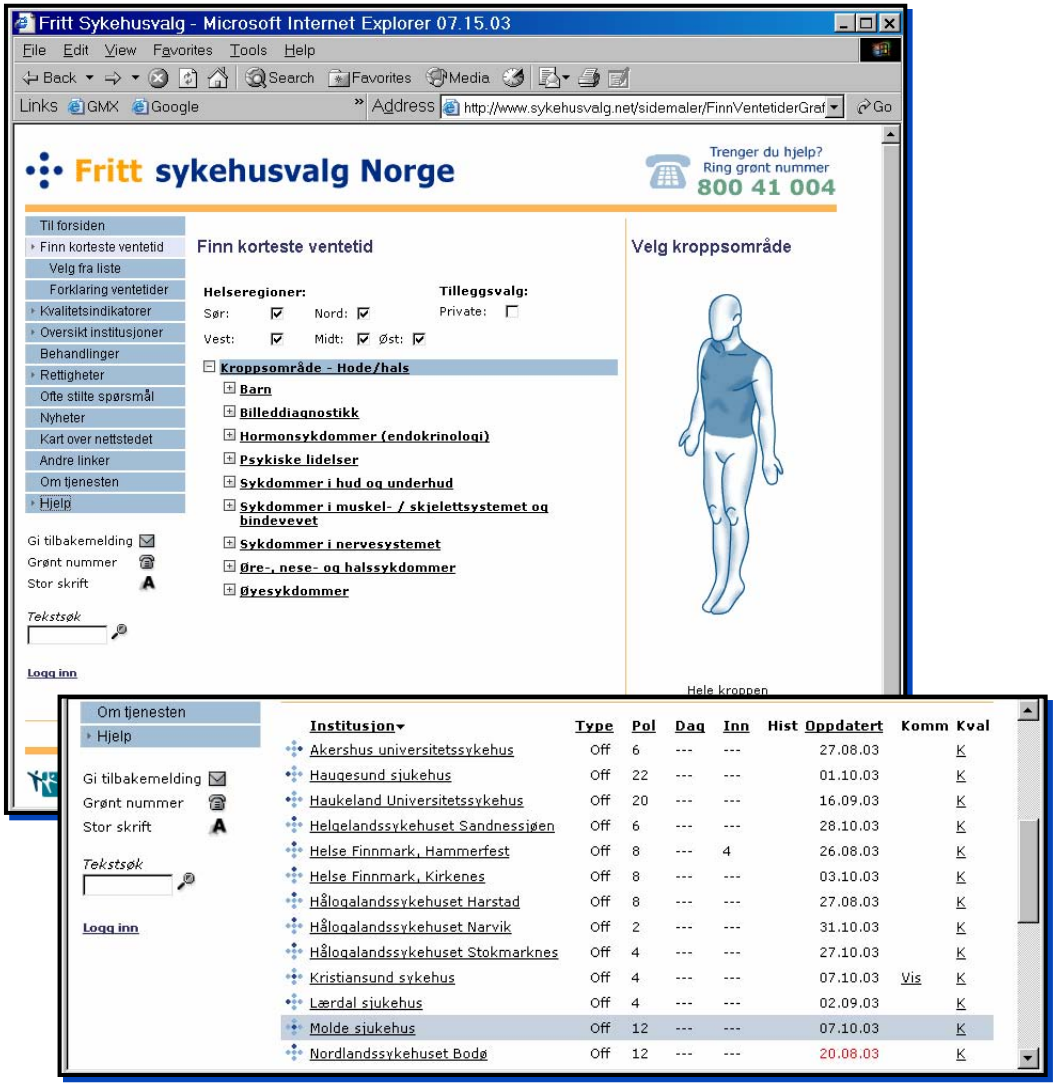
"The guarantee is not a guarantee, it has already become "a goal""
- Leading newspaper

7 ideas to reduce waiting time

	Explanation	Degree of success
4. Introduce real patient choice between providers	• Introduced in Norway in 2001 • Patients can choose where to get treated and have the tools to do so (although most do not utilize this yet) • Tools include publicly available waiting times and some quality indicators for each provider (e.g., patient satisfaction, infections, corridor patients)	• High when executed properly – Gives results but takes time to become effective – Most patients will rely on their doctors' advice regardless of quality indicators, and if doctors have incentives to keep patients in their own hospital/own region (as they currently do in the Norwegian system), introducing choice will have a limited effect – Will only work if patients get *tools* to make informed choices and doctors get incentives that, as a minimum, do not hamper choice

Source: McKinsey <__> provider practice

Free choice of hospital, combined with publicly available information on waiting times, creates incentives for providers to improve



Institusjon	Type	Pol	Dag	Inn	Hist	Oppdatert	Komm	Kval
Akershus universitetssykehus	Off	6	---	---		27.08.03		K
Haugesund sjukehus	Off	22	---	---		01.10.03		K
Haukeland Universitetssykehus	Off	20	---	---		16.09.03		K
Helgelandssykehuset Sandnessjøen	Off	6	---	---		28.10.03		K
Helse Finnmark, Hammerfest	Off	8	---	4		26.08.03		K
Helse Finnmark, Kirkenes	Off	8	---	---		03.10.03		K
Hålogalandssykehuset Harstad	Off	8	---	---		27.08.03		K
Hålogalandssykehuset Narvik	Off	2	---	---		31.10.03		K
Hålogalandssykehuset Stokmarknes	Off	4	---	---		27.10.03		K
Kristiansund sykehus	Off	4	---	---		07.10.03	Vis	K
Lærdal sjukehus	Off	4	---	---		02.09.03		K
Molde sjukehus	Off	12	---	---		07.10.03		K
Nordlandssykehuset Bodø	Off	12	---	---		20.08.03		K

How it works

- Free choice of hospital (since January 2001)
- Patients are free to call toll free number or visit website to find shortest waiting times and book treatment (since May 2003)
- Hospital outcome ratings and rankings of service level by hospital on internet (since September 2003)
- Patient is guaranteed treatment within a certain time period by law

To stay competitive, providers need to achieve an acceptable waiting time and good quality and service

Source: www.sykehusvalg.net, McKinsey analysis

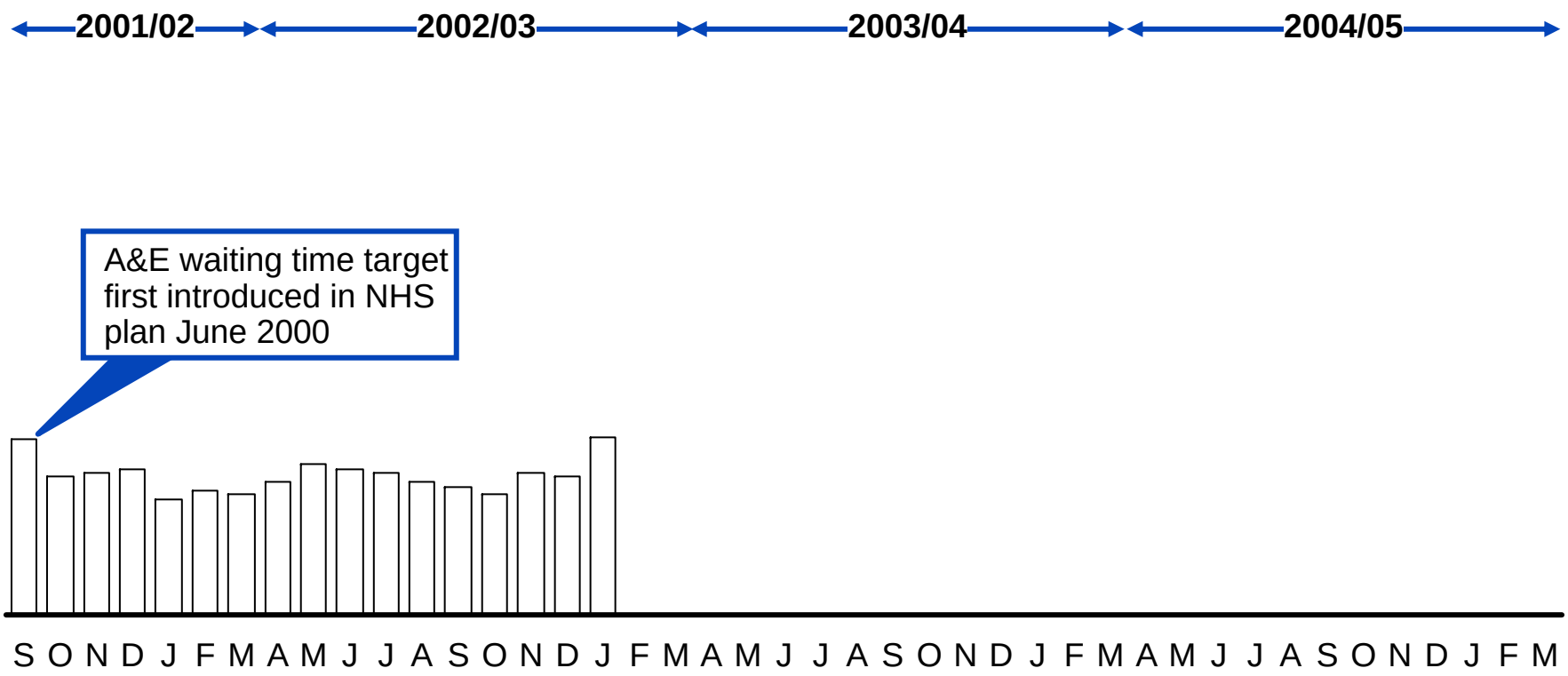
7 ideas to reduce waiting time

	Explanation	Degree of success
5. Change financing system and incentive	• Introduce a financing system based not on lump sum/fixed budgets, but on pay per service delivery (e.g., DRG system) • Introduced in Norway in 1997 – long waiting lists could no longer be used as argument for increased budgets	• High impact – Increases productivity (number of patients treated per hospital/medical staff) – No indication that quality suffers – Staff generally satisfied – However, the change must be executed properly or problems will arise (e.g., upcoding, misguided incentives)

Source: McKinsey Payor Provider Practice

The UK introduced the A&E waiting time target in 2000, but until 2002 performance remained flat

% A&E attenders spending no more than 4 hours in A&E, England

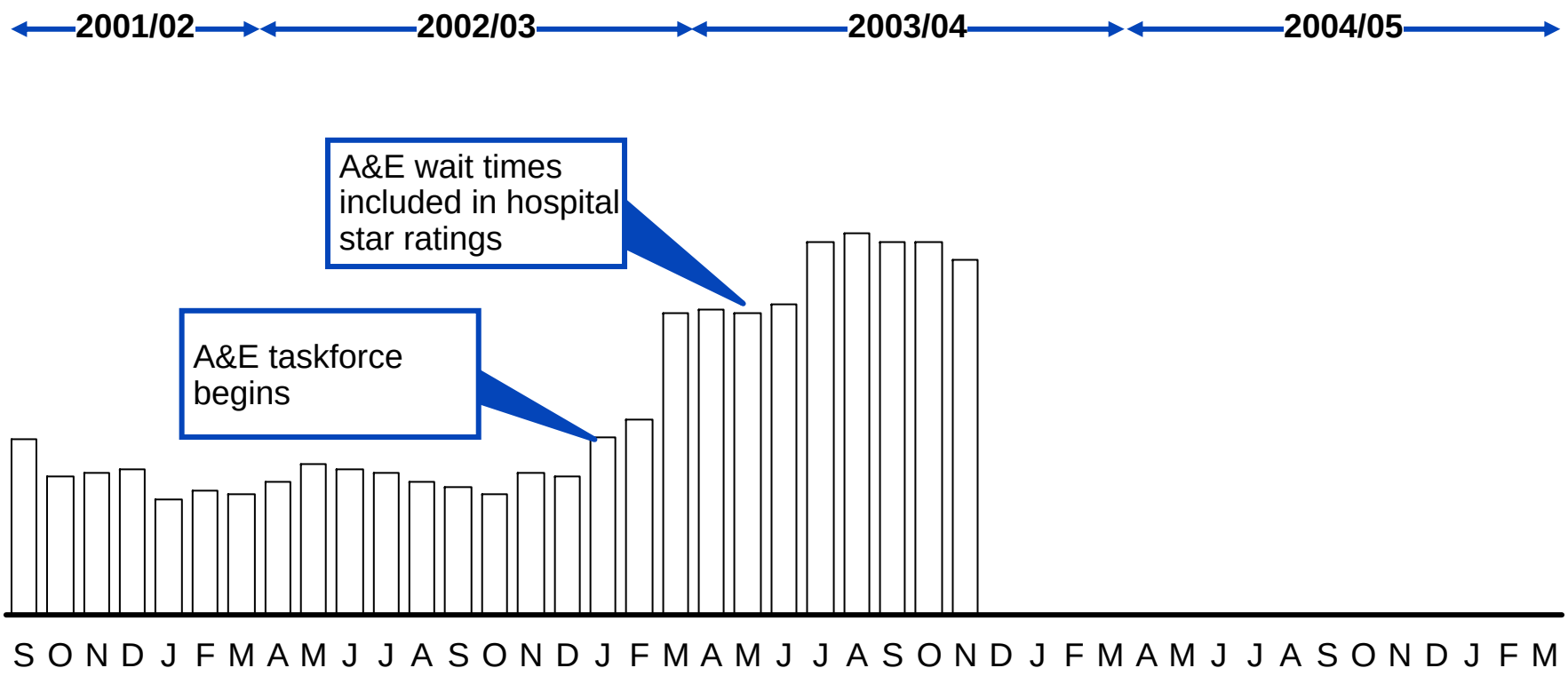


- **The initial target set a maximum wait in A&E of 4 hours from arrival to admission, transfer, or discharge**
- **However performance against this target remained flat until 2002**
  - **A&E goals were not clearly communicated**
  - **Little attention was paid to monitoring A&E performance**

Source: Department of health

2003 saw a step change in performance as a result of making A&E a primary target and including it in hospital ratings

A&E attenders spending no more than 4 hours in A&E, England

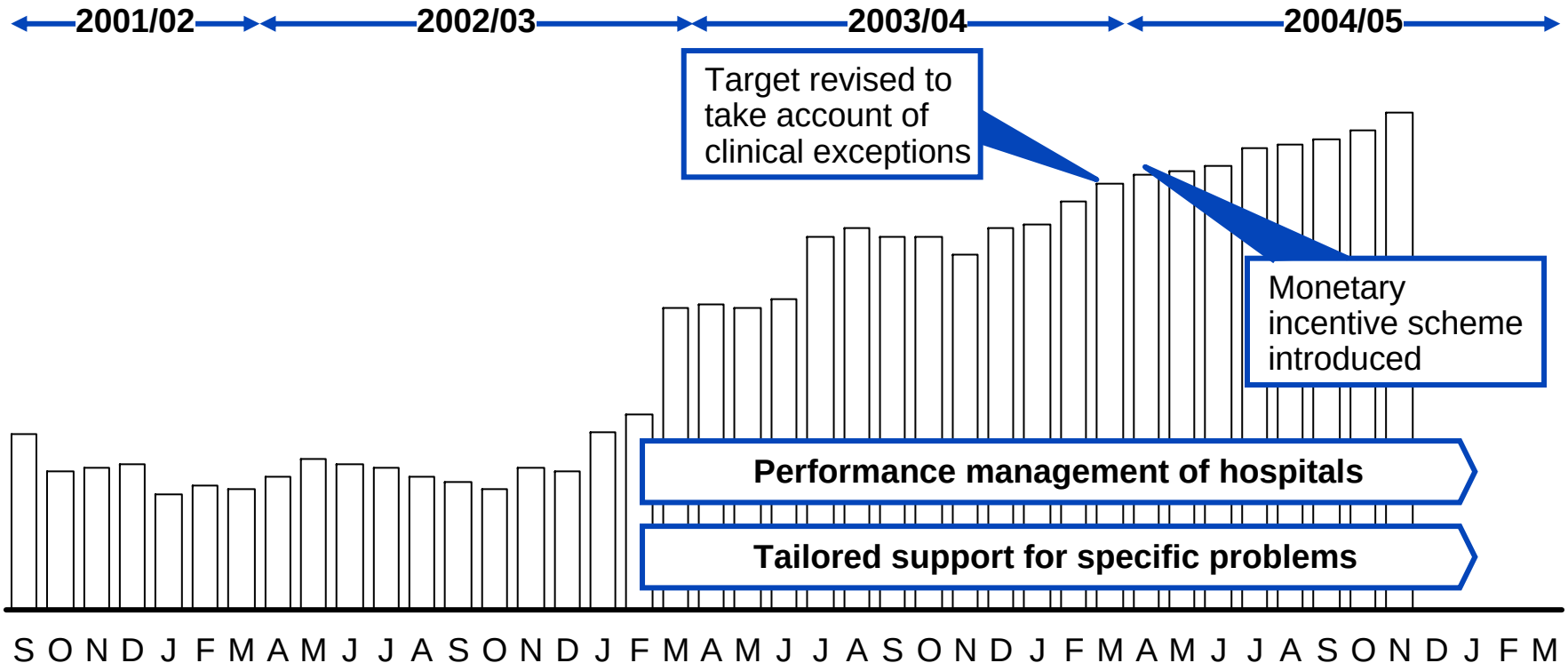


- **A step change in A&E performance was seen in 2003**
  - **A&E waiting time became a primary performance target**
  - **Inclusion of A&E wait times in hospital star ratings made the targets more transparent**
  - **Many hospitals received funds for new facilities, additional staff and Medical Admission Units (MAU)**
  - **The taskforce worked with individual hospitals which had higher than average wait times**

Source: Department of health

Revised target and introduction of incentive scheme brought another step change in A&E performance

A&E attenders spending no more than 4 hours in A&E, England



A second step change in A&E performance was seen in 2004
- **Initial target of 100% was reduced to 98% to account for clinical exceptions**
- **Quarterly bonus of GBP 100,000 started was given to 3-star rated hospitals**
- **More funds were made available to build skills with the establishment of modernization agency**

Source: Department of health

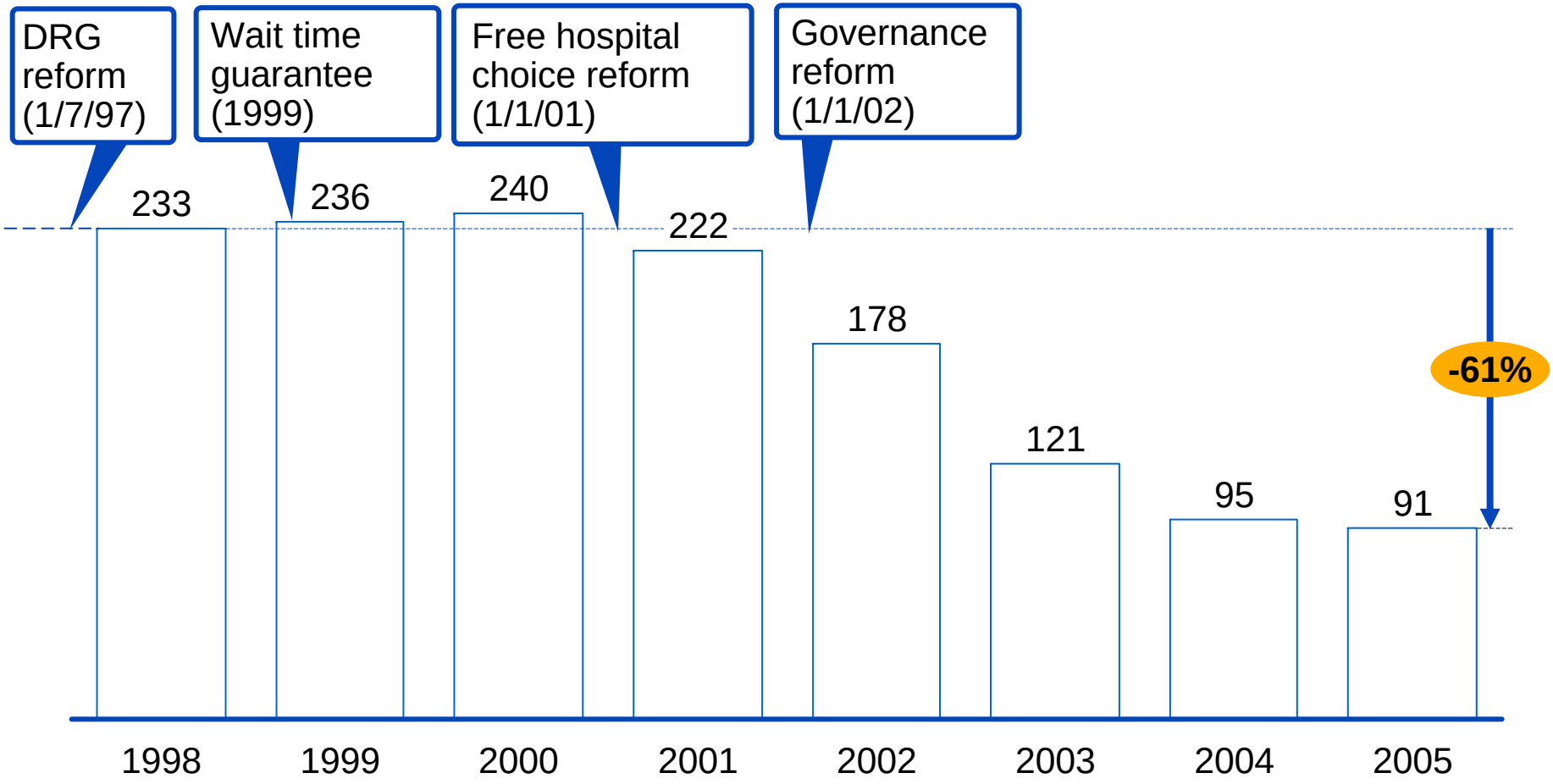
7 ideas to reduce waiting time

	Explanation	Degree of success
6. Change governance model	• Big governance reform introduced in Norway in 2002 • The country divided into five health regions with responsibility of offering necessary specialist care to the inhabitants • Each region has its own independent board with a mix of business and non-profit experienced board members • Each hospital has its own independent board	• High impact – Clearer responsibility for both the quality of health care services, including waiting times, and for the efficiency of service delivery – Several concrete steps taken to rationalize hospital structure and realize economies of scale – Difficult to measure impact statistically, but general experience and knowledge suggests very concrete impact
7. Introducing private providers	• Allow private providers to operate within publicly financed hospital system	• High impact – Reduces waiting times by adding capacity for high-priority areas – Increases existing providers' efficiency and shifts demand/capacity over to better operators – However, some pitfalls exist (prices (DRGs) must be "fair"/correct, system must be set up to avoid cherry-picking, etc.)

Source: McKinsey Payor Provider Practice

The average length of waiting time in Norwegian hospitals has decreased significantly from 2000

Average waiting time, days



* Part of the reduction due to clean up of waiting list to reflect real waiting time

Source: NPR (Norsk Patient Register), McKinsey analysis

Introduce private providers (with public financing)

Capio

- Add capacity to reduce waiting times
- Benchmark – set the standard for what a good operator can achieve
- Introduce new, innovative practices

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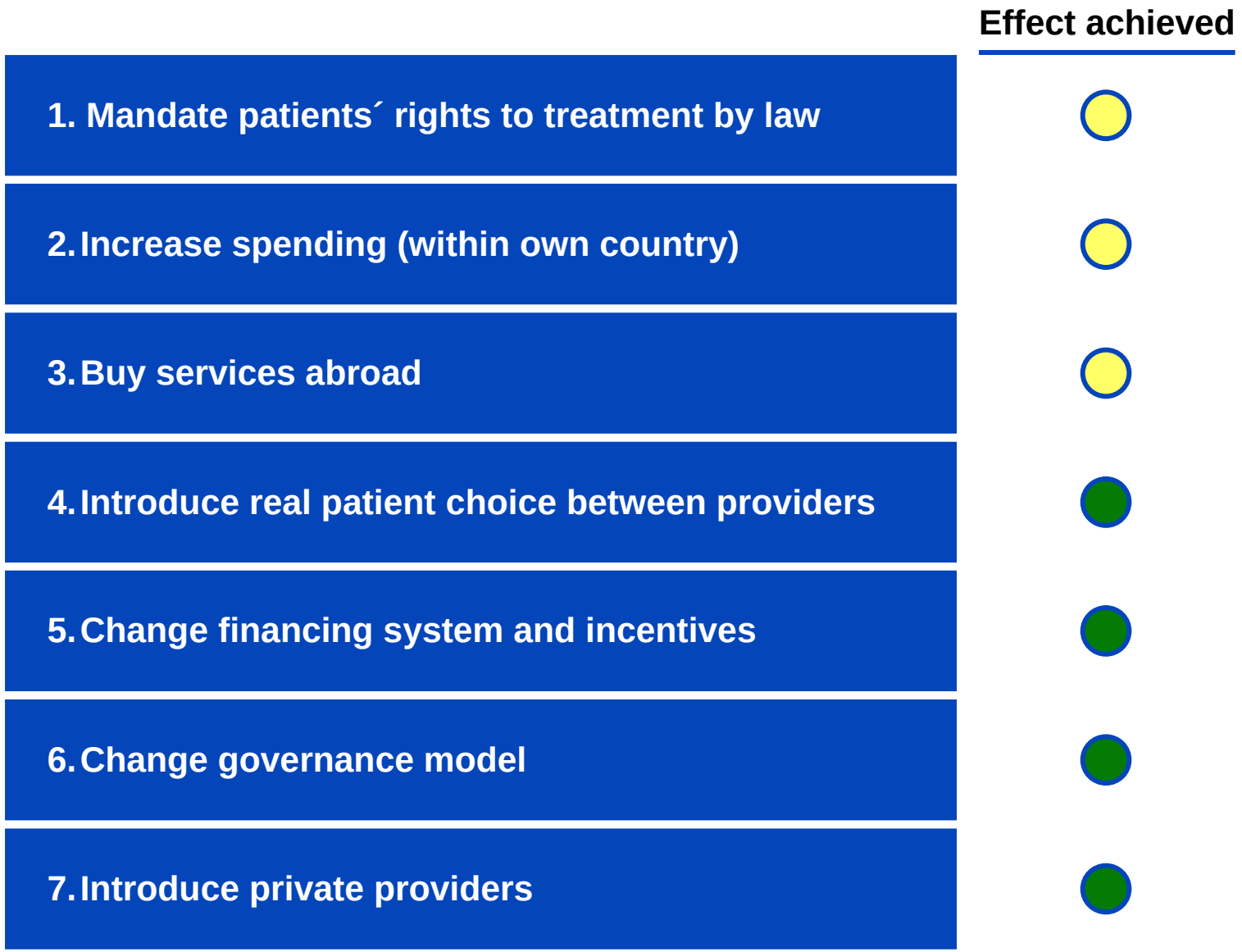
Key takeaways

Key lessons learned – Results from 7 ideas



Key lessons learned

- What you measure is what you get
- Incentives always work, but make sure you get them right
- Be careful when introducing “guarantees”
- Financing mechanisms must be fair and correct and must promote the desired behaviors (system must not allow for cherry picking, or under compensation)
- Patients' choice should drive the changes – tools to promote free choice and improve the overall effectiveness will also reduce wait times