

Beyond the Hospital Walls

Activity Based Funding Versus Integrated Health Care Reform

Summary

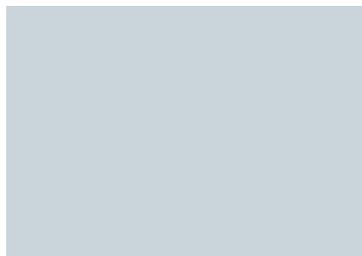
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Summary

The controversial new plan for federal transfer payments to the provinces makes it clear that the current federal government will not use its spending authority to take a leadership role in ensuring the long-term sustainability of our public health system.

DEBATE ABOUT THE CHANGES NEEDED to encourage better, more cost-effective health care in Canada heated up over the past year, spurred by anticipated negotiations on a new Health Accord between the federal and provincial governments. The prospects of a new Accord were sidelined in December 2011, however, when Finance Minister Jim Flaherty announced a controversial new plan for federal transfer payments to the provinces over the next 12 years (transfer payments will go up by 6 per cent per year until 2016/17, and after that will be tied to economic growth rates).

Flaherty's announcement makes it clear that the current federal government will not use its spending authority to take a leadership role in ensuring the long-term sustainability of our public health system. It also puts considerably more pressure on the provinces to find ways to improve quality of care, increase access to health services and minimize cost increases.

Given the changed federal context, it is more important than ever for citizens in BC and across Canada to understand the policy options available to us, and what the research evidence tells us about their effectiveness. It is also important for provincial governments to find new ways to work together (e.g., to share expertise and knowledge, pool resources) to increase the impact of reform strategies designed to improve care and control costs.

This paper examines two policy options now being introduced in BC, both of which are relevant to other provinces; the first a more integrated approach to health care, and the second a new model for hospital funding known as activity based funding.

Under activity based funding, or ABF, health care providers like hospitals are funded based on the number and type of "activities" they actually perform. In the case of BC, the focus is primarily on encouraging hospitals to carry out more surgical procedures. For these services ABF replaces *global funding*, which gives health care providers a set budget each year.

We review the international evidence about the effectiveness of these two approaches, and propose concrete recommendations for BC to pursue in the coming years.

WE CAN AND MUST GET BETTER VALUE FOR OUR HEALTH CARE DOLLARS

Like the rest of Canada, BC faces significant health care challenges, including:

- Lack of coordination between the three parts of the system (primary, acute and community health care);
- Inadequate funding for community health care;
- Inappropriate and ineffective use of hospitals, the most expensive part of the system:
 - Hospital beds taken up by patients who no longer require hospital services—most often the frail elderly who cannot be discharged because of the shortage of community services like residential care and home support;
 - Patients with chronic conditions going to emergency for problems that could be treated in primary care;
 - Seniors admitted to hospital for preventable adverse drug reactions; and
 - Lower-income people hospitalized for chronic conditions that could be treated in the community if these services were available and affordable.

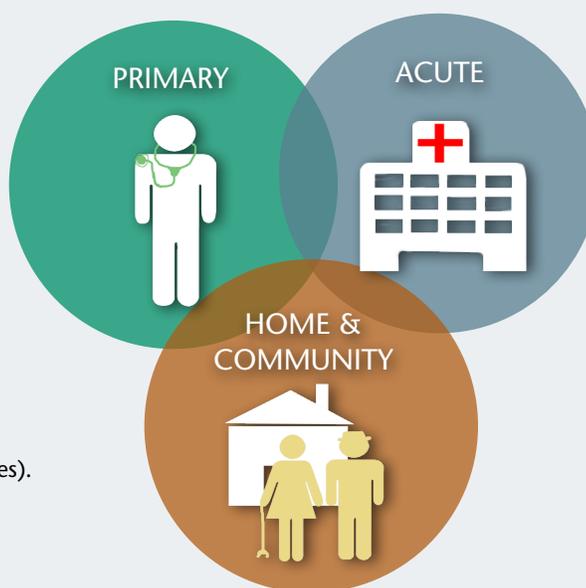
All of these examples point to ineffective and inappropriate use of the most expensive part of our health system—hospitals—and to the importance of creating more adequately funded and better integrated primary and community care services. This would reduce pressure on hospital services and alleviate the problems we constantly hear about in the media: overcrowding and long wait times in emergency and wait times for surgical procedures. It could also reduce the need to expand hospital services in the future.

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Health Care in Canada

Canada's health care system is made up of three intersecting parts:

- primary care (family doctors);
- acute care (e.g., hospitals and emergency services, the most expensive part of the system); and
- home and community care (e.g., residential care for seniors, home support services).



BC'S COMPETING APPROACHES TO HEALTH CARE REFORM: INTEGRATED CARE AND ABF

BC has been experimenting with two very different approaches to improving health care.

On the one hand, the province has made small steps toward integrating all three parts of the health care system, in order to reduce hospital use and provide better continuity of care. This includes the Integrated Primary and Community Care Initiative, which brings together hospitals, primary care, home and community care, and mental health services in the health care planning process for high needs populations, such as the frail elderly and people living with chronic health conditions.

However, there is no dedicated provincial funding for this initiative, and efforts at integration have been hampered by the erosion of funding for community-based services over the past 15 years.

In contrast, the province has put most of its focus on introducing activity based funding. In April 2010, BC's Ministry of Health announced a new three-year strategic agenda that included a plan to shift approximately 20 per cent of hospital funding from the global model to ABF.

Under global funding, hospitals receive a fixed yearly budget to cover all of the services they provide. To stay within budget, hospitals sometimes reduce activity levels or close operating rooms and beds during holidays or over the summer. These measures may save money, but can result in longer surgical waitlists and inefficient use of hospital resources.

Under ABF, health providers receive funding based on the number and type of "activities" they perform.

According to its proponents, ABF improves hospital efficiency by increasing the number of day surgeries as opposed to overnight procedures, and shortening the lengths of stay for other in-hospital services. ABF proponents view it as a key means to address surgical waitlists and overcrowded hospitals.

PROBLEMS WITH ABF

The BC government has made activity based funding a priority, at the very time that senior researchers and policy advisors in countries like the US and Britain—where ABF schemes have been in place for many years—are proposing alternatives that are more compatible with service integration and quality improvement strategies. This shift follows studies showing that because ABF narrowly focuses on reforming hospital funding, it cannot resolve system-wide problems, and may actually inhibit overall system coherence and service integration.

Some of the key concerns about ABF include:

- **ABF DOES NOT ADDRESS THE REAL CAUSES OF HOSPITAL PROBLEMS**

The current problems in BC hospitals – overcrowding, long wait times – are primarily due to pressures from other parts of the health care system, not lack of "activity" in hospitals. For example, in Canada one in nine hospital beds are occupied by "alternate level of care" or ALC patients, most often the frail elderly who need residential care or other community services, but are stuck in hospital because these services are not available. A recently released report from the Wait Time Alliance argues that reducing the number of hospital beds

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occupied by ALC patients is “the most important action that could be taken to improve timely access” to both emergency and elective surgical services.

This suggests that system-wide reforms, particularly improving community care, will have the greatest impact on quality and costs.

- **EFFICIENCY GAINS UNCERTAIN; ADMINISTRATIVE COSTS INCREASE WITH ABF**

The goal of ABF is to encourage greater efficiency by promoting more activity at a lower cost per patient admission (i.e., per unit). However, contradictory and inconclusive findings in the international literature have led researchers to conclude that the evidence of improved efficiency (i.e., reduced per admission costs) with ABF is, at the best, mixed.

At the same time there is little question that ABF leads to higher administrative costs. Because hospitals are no longer guaranteed a certain level of funding under ABF, but instead are paid based on the number and type of surgical activities they perform, there is an incentive to manipulate the reporting (or coding) of procedures. For example, a hospital administrator can use the coding system to claim that procedures they performed were more complex than they actually were. This practice is referred to as “gaming” the system or “up-coding.” Because of this risk, ABF requires increased monitoring and auditing, and thus leads to higher administrative costs.

- **ABF ENCOURAGES OVER-TREATMENT OF SOME POPULATIONS AND UNDER-TREATMENT OF OTHERS**

There is a great deal of evidence from many countries to show that the volume incentives built into ABF create a preference for treating high-volume, low-risk patients over higher-needs, less predictable patients. This means that decisions about whether to provide care may not be based on the potential of that care to improve the health of the patient, but rather on whether the patient is likely to move through the system quickly and without complications. This perverse decision-making can result in over-treating some patient populations and under-treating others. Patients with complex needs and physical disabilities are particularly disadvantaged, because of the difficulties hospitals experience in getting reimbursed for the full costs of caring for these patients under ABF.

- **INCREASES IN DAY SURGERIES MAY HAVE NEGATIVE CONSEQUENCES**

In BC, the first priority for ABF is to increase the number of day as opposed to overnight procedures. This may be problematic given the inadequacy of funding for home health services in BC to support patients post-surgery and the absence of any process for monitoring patient safety and quality of care. Encouraging more day surgeries also opens the door to increasing the role of for-profit clinics, which are allowed to perform surgeries requiring less than 24 hours’ stay.

- **ABF CAN CREATE A MARKET FOR HOSPITAL SERVICES, AND POSSIBLY INCREASES THE ROLE OF PRIVATE PROVIDERS**

By creating a pricing mechanism for individual activities, ABF establishes a quasi-market (internal market) for hospital services, where non-profit hospitals may be expected to compete with each other, and potentially with the private sector, to provide health services based on a set price paid by the government or health authority.

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INTEGRATED HEALTH CARE REFORM: A BETTER WAY TO THINK ABOUT CARE

Tremendous strides have been made in recent years in understanding how to introduce large scale change into health systems, with the goal of providing safe, effective, patient-centred, timely, efficient and equitable care. A growing body of international evidence demonstrates that high performing health care systems can simultaneously improve quality, ensure access, and achieve lower rates of overall expenditure growth.

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Some of the best examples of how to apply a systems approach to health services transformation can be found in the 2008 report, *High Performing Healthcare Systems: Delivering Quality by Design*. The report was part of a project designed to inform Canadians about regional health systems that have been recognized as outstanding in providing both efficient and equitable care. The report featured five case studies: Jonkoping County Council (Sweden), Birmingham East and North Primary Care Trust (England), and three not-for-profit regional health organizations in the US.

In Canada, regional health systems include many distinct services, each with different care processes and limited capacity to share information or work together toward a common goal. This was true in the five case studies as well. In each case a very strategic and quality focused change agenda was initiated by a senior leadership team, working across the entire system, to develop a common purpose, improve care co-ordination, reduce wait times and standardize care processes based on the best available evidence and an integrated approach to information technology. Funding was realigned to population needs in order to make visible the ways in which inadequate care for a patient population in one part of the system (e.g., primary care) resulted in higher costs in another part of the system (e.g., hospitals).

The Story of Two Swedish Counties: Better Results with Service Integration than ABF

Sweden provides an excellent example of the relative benefits of systems integration as compared to ABF for improving care and containing costs. ABF was introduced in some Swedish counties, and not others. In 1992, Stockholm was the first county to shift to an ABF model and to encourage competition by creating an internal market for hospital services. Initially the so-called Stockholm model was very successful, resulting in productivity improvements of 20 per cent in two years. But these improvements proved temporary. By 1997, productivity had declined to the levels observed in 1991, prior to ABF's introduction. Evaluation studies revealed that over the same period greater productivity improvements were achieved in counties that focused on quality improvement and care integration rather than on greater service volume and competition via ABF. In fact, the most marked productivity increases occurred in the county of Jonkoping, one of the high performing regional health systems described in this paper. By 2005, Jonkoping County Council had the best overall ranking (among all 21 county councils in Sweden) in terms of efficiency, timeliness, safety, patient centredness, equity and effectiveness.

Two related system changes were central to the quality improvement strategies in all five case studies:

- A commitment to decision making at all levels (the practitioner, service, and system level) based on quality guidelines/performance measures that are evidence-based and focused on clinical outcomes, care co-ordination and patient experience; and
- A focus on service integration to improve care for people with ongoing chronic conditions and/or complex needs in the community, and to reduce the inappropriate use of high-cost emergency and in-patient hospital services.

Throughout the case studies there are examples showing that improved quality of care leads to more effective use of health care dollars. These include:

- A 50 per cent reduction in hospital readmission rates as a result of lowering the levels of post-operative infections in Intermountain Healthcare in Utah;
- A 50 per cent decline in unplanned hospital visits by mental health clients receiving more consistent and comprehensive care in the community in Birmingham, UK; and
- A 20 per cent reduction in hospital utilization due to improved care co-ordination for people with chronic conditions in Jonkoping County, Sweden.

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RECOMMENDATIONS FOR BC HEALTH CARE REFORMS

Our review of best practices in health system reform points to many opportunities for BC to improve quality and access to health care, while also controlling the rate of expenditure growth. Health reform in BC can build not only on the experience of high performing health systems internationally, but also on a number of successful smaller-scale initiatives already underway in BC. These include the regional improvement strategy in the Northern Health Authority, the integration initiatives in communities around BC, and the pre-surgery hip and knee programs in the Lower Mainland. What is needed now is provincial leadership to support system-wide transformation and the scaling up of the successful local and regional initiatives.

Based on the international evidence of best practices in health reform, we have developed the following seven recommendations for the BC government:

- Develop clear and consistent goals that promote collaboration across health services and providers, and work toward these goals at multiple levels simultaneously.
- Determine the root causes driving hospital overcrowding and long wait times and use this information to guide provincial and regional improvement initiatives.
- Develop and report on broad-based performance measures related to patient clinical outcomes, care coordination, and patient experiences. Patient reported outcome measures, or PROMS, are particularly important to consider given the growing recognition internationally of the value of patients' perspectives in quality improvement initiatives.
- Provide adequate provincial funding to support the integration of community care with primary care.
- Provide more opportunities to introduce population-based funding and to test different mechanisms for sharing accountability and working across services and providers, beginning with specific high needs populations (i.e., the frail elderly and people living with serious mental illness).

- Ensure that at least a portion of savings from any quality improvement are retained and reinvested by the organizations/providers involved in initiating the change. This is seen as one of the best ways to ensure buy-in and momentum for change among health care providers.
- Avoid initiatives, such as ABF, that do not explicitly promote system integration and coherence, but instead increase the costs and activity in the most expensive part of the health system: hospitals.

We need to shift the debate from a discussion of single issues to a broader discussion of how to improve both the quality and cost-effectiveness of our overall health system.

Many of these recommendations would have even greater impact if they were part of the larger national (and to begin with inter-provincial) discussion about how to ensure the long-term sustainability of our public health system. The capacity to implement broad based performance measures, integrate community health services under the Medicare umbrella, and develop new ways of sharing accountability across services and providers would be greatly enhanced if these initiatives were part of a national effort to improve the quality and cost-effectiveness of Canada's public health care system.

Health system change and innovation is the main focus of the premiers' health summit planned for Victoria in early 2012. In a summit-related news conference in July 2011, Saskatchewan premier Brad Wall talked about the benefits of contracting out orthopedic procedures to private clinics, and BC premier Christy Clark talked about activity based funding as a way to drive down wait times for hospital procedures. Instead of focusing on the broader question of how to transform Canada's public health system into a high performing system, the Saskatchewan and BC premiers focused on a single issue—wait times for hospital procedures. And yet we know from the international evidence that wait times frequently reflect broader system problems related to the interface between acute, primary and specialist services and inadequate funding and coordination within the community health system. The failure to address these broader systemic issues will only exacerbate the wait time challenge.

We need to shift the debate from a discussion of single issues to a broader discussion of how to improve both the quality and cost-effectiveness of our overall health system. We recommend that more emphasis is placed on understanding the patient's experience across the continuum of care, and on developing a funding mechanism that allows an integrated set of providers to be accountable for providing appropriate and cost-effective care.



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