UBC CENTRE FOR
HEALTH SERVICES AND POLICY RESEARCH

What if…
Activity-based funding and global budgets were used to fund hospital care?

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Main Issue

Historically, acute, hospital-based care is funded through global budgets.

Advantages:

- Provide budget predictability
- Effective cost control
- Covers a variety of care – irrespective of costs or volume – within a given period of time

Limitations:

- No reward for increased volume
- No incentives for improving quality or efficiency
- Disincentives for discharging patients to post-acute care (i.e., exchanging relatively less expensive patients for relatively more expensive patients)

Main Issue

- Consequently, persistent problems across provinces:
  - ⇧ Alternate level of care (ALC)
  - ⇧ Surgical wait times
  - ⇧ Backlog in emergency rooms (ER)

- Hospitals also represent the single largest component of health care budgets:
  - In 2008, $49.4 billion or ~29% of all health care spending in Canada

- Has prompted many provinces to reexamine the way it funds acute care.

Proposed Option

Blending activity-based funding (ABF)
with global budgets
for funding acute care is one option
under consideration by policy makers
to increase volume and improve efficiency.

Activity-Based Funding

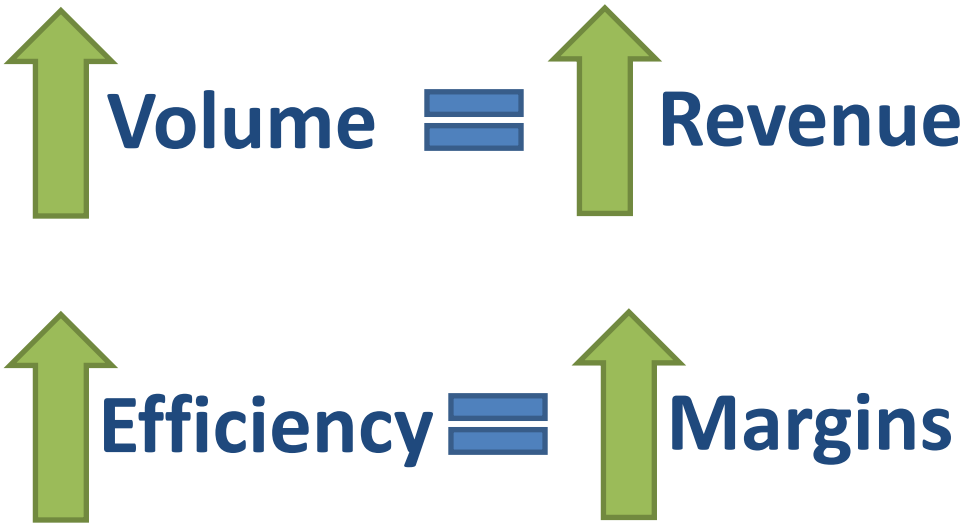
- Remunerates facilities based on:
  1. volume of services
  2. characteristics of the patients

- Patients assigned to unique groups based on clinical and demographic information

- Each group is associated with a predetermined funding amount

- Hospitals retain the difference between their costs of delivering care and the payment amount

Activity-Based Funding



Evidence

Widely used in the developed world

- First introduced in the U.S. Medicare system in early 1980s.

Advantages

- ⇧ volumes of care
- ⇩ lengths of stay
- ⇔mortality (perhaps)
- ⇧ efficiency (through change in labour mix)
- ⇩ Incentives to cream skim

Disadvantages

- ⇧ overall hospital spending (due to higher volume)
- ⇧ in procedures offering the highest “margins”
- ⇧ Incentives to provide unnecessary care with unknown benefit to patients quality of life

Challenges

Hospital Administrators

- Responsible for managing both costs and revenue
- Delivering more efficient care
- Avoiding "crowding-out" (i.e., prioritizing care that has highest margins at the expense of other care)

Challenges

Policy Makers

- Getting the price right
- "Up-coding" by hospitals (i.e., characterizing patients as being more complex than they actually are)
- Monitor clinical quality
- Aligning incentives across the continuum of care
  - ABF initiatives may be moot if no post-acute care location available (e.g., ALC will rise)
- Budget for an increase in hospital costs

Implications for Canada

- Cost and capacity pressures are motivating policy makers to look for new ways to fund hospitals in Canada

- Rich body of evidence from the international community, but the generalizability of this evidence to the Canadian context is not known:
  - Small and rural hospitals
  - Labour unions
  - “Competition” amongst hospitals

Implications for Canada

- Ongoing implementations across Canada will provide much needed insight:
  - BC committing $225 million to purchase additional surgical and diagnostic procedures across the province using ABF

- Provinces need to exercise caution and their own political and health system environments prior to embarking on ABF

Thank You

www.healthcarefunding.ca